

House Amendment 8604

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1 1 Amend the Senate amendment, H=8439, to House File
1 2 2539, as amended, passed, and reprinted by the House,
1 3 as follows:
1 4 #1. By striking page 1, line 3, through page 42,
1 5 line 14, and inserting the following:
1 6 <#____. By striking everything after the enacting
1 7 clause and inserting the following:
1 8 <DIVISION I
1 9 HEALTH CARE COVERAGE INTENT
1 10 Section 1. DECLARATION OF INTENT.
1 11 1. It is the intent of the general assembly to
1 12 progress toward achievement of the goal that all
1 13 Iowans have health care coverage with the following
1 14 priorities:
1 15 a. The goal that all children in the state have
1 16 health care coverage which meets certain standards of
1 17 quality and affordability with the following
1 18 priorities:
1 19 (1) Covering all children who are declared
1 20 eligible for the medical assistance program or the
1 21 hawk=i program pursuant to chapter 514I no later than
1 22 January 1, 2011.
1 23 (2) Building upon the current hawk=i program by
1 24 creating a hawk=i expansion program to provide
1 25 coverage to children who meet the hawk=i program's
1 26 eligibility criteria but whose income is at or below
1 27 three hundred percent of the federal poverty level,
1 28 beginning July 1, 2009.
1 29 (3) If federal reauthorization of the state
1 30 children's health insurance program provides
1 31 sufficient federal allocations to the state and
1 32 authorization to cover such children as an option
1 33 under the state children's health insurance program,
1 34 requiring the department of human services to expand
1 35 coverage under the state children's health insurance
1 36 program to cover children with family incomes at or
1 37 below three hundred percent of the federal poverty
1 38 level, with appropriate cost sharing established for
1 39 families with incomes above two hundred percent of the
1 40 federal poverty level.
1 41 b. The goal that the Iowa comprehensive health
1 42 insurance association, in consultation with the Iowa
1 43 choice health care coverage advisory council
1 44 established in section 514E.6, develop a comprehensive
1 45 plan to first cover all children without health care
1 46 coverage that utilizes and modifies existing public
1 47 programs including the medical assistance program, the
1 48 hawk=i program, and the hawk=i expansion program, and
1 49 then to provide access to private unsubsidized,
1 50 affordable, qualified health care coverage for
2 1 children, adults, and families, who are not otherwise
2 2 eligible for health care coverage through public
2 3 programs, that is available for purchase by January 1,
2 4 2010.
2 5 c. The goal of decreasing health care costs and
2 6 health care coverage costs by instituting health
2 7 insurance reforms that assure the availability of
2 8 private health insurance coverage for Iowans by
2 9 addressing issues involving guaranteed availability
2 10 and issuance to applicants, preexisting condition
2 11 exclusions, portability, and allowable or required
2 12 pooling and rating classifications.
2 13 DIVISION II
2 14 HAWK-I AND MEDICAID EXPANSION
2 15 Sec. 2. Section 249A.3, subsection 1, paragraph 1,
2 16 Code Supplement 2007, is amended to read as follows:
2 17 1. Is an infant whose income is not more than two
2 18 hundred percent of the federal poverty level, as
2 19 defined by the most recently revised income guidelines
2 20 published by the United States department of health
2 21 and human services. Additionally, effective July 1,
2 22 2009, medical assistance shall be provided to an
2 23 infant whose family income is at or below three
2 24 hundred percent of the federal poverty level, as

2 25 defined by the most recently revised poverty income
2 26 guidelines published by the United States department
2 27 of health and human services, if otherwise eligible.

2 28 Sec. 3. Section 249A.3, Code Supplement 2007, is
2 29 amended by adding the following new subsection:

2 30 NEW SUBSECTION. 14. Once initial eligibility for
2 31 the family medical assistance program=related medical
2 32 assistance is determined for a child described under
2 33 subsection 1, paragraphs "b", "f", "g", "j", "k", "l",
2 34 or "n" or under subsection 2, paragraphs "e", "f", or
2 35 "h", the department shall provide continuous
2 36 eligibility for a period of up to twelve months, until
2 37 the child's next annual review of eligibility under
2 38 the medical assistance program, if the child would
2 39 otherwise be determined ineligible due to excess
2 40 countable income but otherwise remains eligible.

2 41 Sec. 4. NEW SECTION. 422.12K INCOME TAX FORM ==
2 42 INDICATION OF DEPENDENT CHILD HEALTH CARE COVERAGE.

2 43 1. The director shall draft the income tax form to
2 44 allow beginning with the tax returns for tax year
2 45 2008, a person who files an individual or joint income
2 46 tax return with the department under section 422.13 to
2 47 indicate the presence or absence of health care
2 48 coverage for each dependent child for whom an
2 49 exemption is claimed.

2 50 2. Beginning with the income tax return for tax
3 1 year 2008, a person who files an individual or joint
3 2 income tax return with the department under section
3 3 422.13, may report on the income tax return, in the
3 4 form required, the presence or absence of health care
3 5 coverage for each dependent child for whom an
3 6 exemption is claimed.

3 7 a. If the taxpayer indicates on the income tax
3 8 return that a dependent child does not have health
3 9 care coverage, and the income of the taxpayer's tax
3 10 return does not exceed the highest level of income
3 11 eligibility standard for the medical assistance
3 12 program pursuant to chapter 249A or the hawk=i program
3 13 pursuant to chapter 514I, the department shall send a
3 14 notice to the taxpayer indicating that the dependent
3 15 child may be eligible for the medical assistance
3 16 program or the hawk=i program and providing
3 17 information about how to enroll in the programs.

3 18 b. Notwithstanding any other provision of law to
3 19 the contrary, a taxpayer shall not be subject to a
3 20 penalty for not providing the information required
3 21 under this section.

3 22 c. The department shall consult with the
3 23 department of human services in developing the tax
3 24 return form and the information to be provided to tax
3 25 filers under this section.

3 26 3. The department, in cooperation with the
3 27 department of human services, shall adopt rules
3 28 pursuant to chapter 17A to administer this section,
3 29 including rules defining "health care coverage" for
3 30 the purpose of indicating its presence or absence on
3 31 the tax form.

3 32 4. The department, in cooperation with the
3 33 department of human services, shall report, annually,
3 34 to the governor and the general assembly all of the
3 35 following:

3 36 a. The number of Iowa families, by income level,
3 37 claiming the state income tax exemption for dependent
3 38 children.

3 39 b. The number of Iowa families, by income level,
3 40 claiming the state income tax exemption for dependent
3 41 children who also indicate the presence or absence of
3 42 health care coverage for the dependent children.

3 43 c. The effect of the reporting requirements and
3 44 provision of information requirements under this
3 45 section on the number and percentage of children in
3 46 the state who are uninsured.

3 47 Sec. 5. Section 514I.1, subsection 4, Code 2007,
3 48 is amended to read as follows:

3 49 4. It is the intent of the general assembly that
3 50 the hawk=i program be an integral part of the
4 1 continuum of health insurance coverage and that the
4 2 program be developed and implemented in such a manner
4 3 as to facilitate movement of families between health
4 4 insurance providers and to facilitate the transition
4 5 of families to private sector health insurance

4 6 coverage. It is the intent of the general assembly in
4 7 developing such continuum of health insurance coverage
4 8 and in facilitating such transition, that beginning
4 9 July 1, 2009, the department implement the hawk=i
4 10 expansion program.

4 11 Sec. 6. Section 514I.1, Code 2007, is amended by
4 12 adding the following new subsection:

4 13 NEW SUBSECTION. 5. It is the intent of the
4 14 general assembly that if federal reauthorization of
4 15 the state children's health insurance program provides
4 16 sufficient federal allocations to the state and
4 17 authorization to cover such children as an option
4 18 under the state children's health insurance program,
4 19 the department shall expand coverage under the state
4 20 children's health insurance program to cover children
4 21 with family incomes at or below three hundred percent
4 22 of the federal poverty level.

4 23 Sec. 7. Section 514I.2, Code 2007, is amended by
4 24 adding the following new subsection:

4 25 NEW SUBSECTION. 7A. "Hawk=i expansion program" or
4 26 "hawk=i expansion" means the healthy and well kids in
4 27 Iowa expansion program created in section 514I.12 to
4 28 provide health insurance to children who meet the
4 29 hawk=i program eligibility criteria pursuant to
4 30 section 514I.8, with the exception of the family
4 31 income criteria, and whose family income is at or
4 32 below three hundred percent of the federal poverty
4 33 level, as defined by the most recently revised poverty
4 34 income guidelines published by the United States
4 35 department of health and human services.

4 36 Sec. 8. Section 514I.5, subsection 7, paragraph d,
4 37 Code Supplement 2007, is amended to read as follows:

4 38 d. Develop, with the assistance of the department,
4 39 an outreach plan, and provide for periodic assessment
4 40 of the effectiveness of the outreach plan. The plan
4 41 shall provide outreach to families of children likely
4 42 to be eligible for assistance under the program, to
4 43 inform them of the availability of and to assist the
4 44 families in enrolling children in the program. The
4 45 outreach efforts may include, but are not limited to,
4 46 solicitation of cooperation from programs, agencies,
4 47 and other persons who are likely to have contact with
4 48 eligible children, including but not limited to those
4 49 associated with the educational system, and the
4 50 development of community plans for outreach and
5 1 marketing. Other state agencies shall assist the
5 2 department in outreach efforts to potentially eligible
5 3 children and their families.

5 4 Sec. 9. Section 514I.5, subsection 7, Code
5 5 Supplement 2007, is amended by adding the following
5 6 new paragraph:

5 7 NEW PARAGRAPH. 1. Develop options and
5 8 recommendations to allow children eligible for the
5 9 hawk=i or hawk=i expansion program to participate in
5 10 qualified employer=sponsored health plans through a
5 11 premium assistance program. The options and
5 12 recommendations shall ensure reasonable alignment
5 13 between the benefits and costs of the hawk=i and
5 14 hawk=i expansion programs and the employer=sponsored
5 15 health plans consistent with federal law. The options
5 16 and recommendations shall be completed by January 1,
5 17 2009, and submitted to the governor and the general
5 18 assembly for consideration as part of the hawk=i and
5 19 hawk=i expansion programs.

5 20 Sec. 10. Section 514I.7, subsection 2, paragraph
5 21 a, Code 2007, is amended to read as follows:

5 22 a. Determine individual eligibility for program
5 23 enrollment based upon review of completed applications
5 24 and supporting documentation. The administrative
5 25 contractor shall not enroll a child who has group
5 26 health coverage ~~or any child who has dropped coverage~~
5 27 ~~in the previous six months, unless the coverage was~~
5 28 ~~involuntarily lost or unless the reason for dropping~~
5 29 ~~coverage is allowed by rule of the board.~~

5 30 Sec. 11. Section 514I.8, subsection 1, Code 2007,
5 31 is amended to read as follows:

5 32 1. Effective July 1, 1998, and notwithstanding any
5 33 medical assistance program eligibility criteria to the
5 34 contrary, medical assistance shall be provided to, or
5 35 on behalf of, an eligible child under the age of
5 36 nineteen whose family income does not exceed one

5 37 hundred thirty=three percent of the federal poverty
5 38 level, as defined by the most recently revised poverty
5 39 income guidelines published by the United States
5 40 department of health and human services.
5 41 Additionally, effective July 1, 2000, and
5 42 notwithstanding any medical assistance program
5 43 eligibility criteria to the contrary, medical
5 44 assistance shall be provided to, or on behalf of, an
5 45 eligible infant whose family income does not exceed
5 46 two hundred percent of the federal poverty level, as
5 47 defined by the most recently revised poverty income
5 48 guidelines published by the United States department
5 49 of health and human services. Effective July 1, 2009,
5 50 and notwithstanding any medical assistance program

6 1 eligibility criteria to the contrary, medical
6 2 assistance shall be provided to, or on behalf of, an
6 3 eligible infant whose family income is at or below
6 4 three hundred percent of the federal poverty level, as
6 5 defined by the most recently revised poverty income
6 6 guidelines published by the United States department
6 7 of health and human services.

6 8 Sec. 12. Section 514I.10, subsection 2, Code 2007,
6 9 is amended to read as follows:

6 10 2. Cost sharing for eligible children whose family
6 11 income equals ~~or exceeds~~ one hundred fifty percent but
6 12 does not exceed two hundred percent of the federal
6 13 poverty level may include a premium or copayment
6 14 amount which does not exceed five percent of the
6 15 annual family income. The amount of any premium or
6 16 the copayment amount shall be based on family income
6 17 and size.

6 18 Sec. 13. Section 514I.11, subsections 1 and 3,
6 19 Code 2007, are amended to read as follows:

6 20 1. A hawk=i trust fund is created in the state
6 21 treasury under the authority of the department of
6 22 human services, in which all appropriations and other
6 23 revenues of the program and the hawk=i expansion
6 24 program such as grants, contributions, and participant
6 25 payments shall be deposited and used for the purposes
6 26 of the program and the hawk=i expansion program. The
6 27 moneys in the fund shall not be considered revenue of
6 28 the state, but rather shall be funds of the program.

6 29 3. Moneys in the fund are appropriated to the
6 30 department and shall be used to offset any program and
6 31 hawk=i expansion program costs.

6 32 Sec. 14. NEW SECTION. 514I.12 HAWK=I EXPANSION
6 33 PROGRAM.

6 34 1. All children less than nineteen years of age
6 35 who meet the hawk=i program eligibility criteria
6 36 pursuant to section 514I.8, with the exception of the
6 37 family income criteria, and whose family income is at
6 38 or below three hundred percent of the federal poverty
6 39 level, shall be eligible for the hawk=i expansion
6 40 program.

6 41 2. To the greatest extent possible, the provisions
6 42 of section 514I.4, relating to the director and
6 43 department duties and powers, section 514I.5 relating
6 44 to the hawk=i board, section 514I.6 relating to
6 45 participating insurers, and section 514I.7 relating to
6 46 the administrative contractor shall apply to the
6 47 hawk=i expansion program. The department shall adopt
6 48 any rules necessary, pursuant to chapter 17A, and
6 49 shall amend any existing contracts to facilitate the
6 50 application of such sections to the hawk=i expansion
7 1 program.

7 2 3. The hawk=i board shall establish by rule
7 3 pursuant to chapter 17A, the cost=sharing amounts for
7 4 children under the hawk=i expansion program. The
7 5 rules shall include criteria for modification of the
7 6 cost=sharing amounts by the board.

7 7 Sec. 15. MAXIMIZATION OF ENROLLMENT AND RETENTION
7 8 == MEDICAL ASSISTANCE AND HAWK=I PROGRAMS.

7 9 1. The department of human services, in
7 10 collaboration with the department of education, the
7 11 department of public health, the division of insurance
7 12 of the department of commerce, the hawk=i board,
7 13 consumers who are not recipients of or advocacy groups
7 14 representing recipients of the medical assistance or
7 15 hawk-i program, the covering kids and families
7 16 coalition, and the covering kids now task force, shall
7 17 develop a plan to maximize enrollment and retention of

7 18 eligible children in the hawk=i and medical assistance
7 19 programs. In developing the plan, the collaborative
7 20 shall review, at a minimum, all of the following
7 21 strategies:

7 22 a. Streamlined enrollment in the hawk=i and
7 23 medical assistance programs. The collaborative shall
7 24 identify information and documentation that may be
7 25 shared across departments and programs to simplify the
7 26 determination of eligibility or eligibility factors,
7 27 and any interagency agreements necessary to share
7 28 information consistent with state and federal
7 29 confidentiality and other applicable requirements.

7 30 b. Conditional eligibility for the hawk=i and
7 31 medical assistance programs.

7 32 c. Expedited renewal for the hawk=i and medical
7 33 assistance programs.

7 34 2. Following completion of the review the
7 35 department of human services shall compile the plan
7 36 which shall address all of the following relative to
7 37 implementation of the strategies specified in
7 38 subsection 1:

7 39 a. Federal limitations and quantifying of the risk
7 40 of federal disallowance.

7 41 b. Any necessary amendment of state law or rule.

7 42 c. Budgetary implications and cost=benefit
7 43 analyses.

7 44 d. Any medical assistance state plan amendments,
7 45 waivers, or other federal approval necessary.

7 46 e. An implementation time frame.

7 47 3. The department of human services shall submit
7 48 the plan to the governor and the general assembly no
7 49 later than December 1, 2008.

7 50 Sec. 16. MEDICAL ASSISTANCE, HAWK=I, AND HAWK=I
8 1 EXPANSION PROGRAMS == COVERING CHILDREN ==
8 2 APPROPRIATION. There is appropriated from the general
8 3 fund of the state to the department of human services
8 4 for the designated fiscal years, the following
8 5 amounts, or so much thereof as is necessary, for the
8 6 purpose designated:

8 7 To cover children as provided in this Act under the
8 8 medical assistance, hawk=i, and hawk=i expansion
8 9 programs and outreach under the current structure of
8 10 the programs:
8 11 FY 2008=2009 \$ 4,800,000
8 12 FY 2009=2010 \$ 14,800,000
8 13 FY 2010=2011 \$ 24,800,000

8 14 DIVISION III
8 15 IOWA CHOICE HEALTH CARE COVERAGE
8 16 AND ADVISORY COUNCIL

8 17 Sec. 17. Section 514E.1, Code 2007, is amended by
8 18 adding the following new subsections:

8 19 NEW SUBSECTION. 14A. "Iowa choice health care
8 20 coverage advisory council" or "advisory council" means
8 21 the advisory council created in section 514E.6.

8 22 NEW SUBSECTION. 21. "Qualified health care
8 23 coverage" means creditable coverage which meets
8 24 minimum standards of quality and affordability as
8 25 determined by the association by rule.

8 26 Sec. 18. Section 514E.2, subsection 3, unnumbered
8 27 paragraph 1, Code 2007, is amended to read as follows:

8 28 The association shall submit to the commissioner a
8 29 plan of operation for the association and any
8 30 amendments necessary or suitable to assure the fair,
8 31 reasonable, and equitable administration of the
8 32 association. The plan of operation shall include
8 33 provisions for the development of a comprehensive

8 34 health care coverage plan as provided in section
8 35 514E.5. In developing the comprehensive plan the
8 36 association shall give deference to the
8 37 recommendations made by the advisory council as
8 38 provided in section 514E.6, subsection 1. The

8 39 association shall approve or disapprove but shall not
8 40 modify recommendations made by the advisory council.

8 41 Recommendations that are approved shall be included in
8 42 the plan of operation submitted to the commissioner.

8 43 Recommendations that are disapproved shall be
8 44 submitted to the commissioner with reasons for the
8 45 disapproval. The plan of operation becomes effective

8 46 upon approval in writing by the commissioner prior to
8 47 the date on which the coverage under this chapter must
8 48 be made available. After notice and hearing, the

8 49 commissioner shall approve the plan of operation if
8 50 the plan is determined to be suitable to assure the
9 1 fair, reasonable, and equitable administration of the
9 2 association, and provides for the sharing of
9 3 association losses, if any, on an equitable and
9 4 proportionate basis among the member carriers. If the
9 5 association fails to submit a suitable plan of
9 6 operation within one hundred eighty days after the
9 7 appointment of the board of directors, or if at any
9 8 later time the association fails to submit suitable
9 9 amendments to the plan, the commissioner shall adopt,
9 10 pursuant to chapter 17A, rules necessary to implement
9 11 this section. The rules shall continue in force until
9 12 modified by the commissioner or superseded by a plan
9 13 submitted by the association and approved by the
9 14 commissioner. In addition to other requirements, the
9 15 plan of operation shall provide for all of the
9 16 following:

9 17 Sec. 19. NEW SECTION. 514E.5 IOWA CHOICE HEALTH
9 18 CARE COVERAGE.

9 19 1. The association, in consultation with the Iowa
9 20 choice health care coverage advisory council, shall
9 21 develop a comprehensive health care coverage plan to
9 22 provide health care coverage to all children without
9 23 such coverage, that utilizes and modifies existing
9 24 public programs including the medical assistance
9 25 program, hawk=i program, and hawk=i expansion program,
9 26 and to provide access to private unsubsidized,
9 27 affordable, qualified health care coverage to children
9 28 who are not otherwise eligible for health care
9 29 coverage through public programs.

9 30 2. The comprehensive plan developed by the
9 31 association and the advisory council, shall also
9 32 develop and recommend options to provide access to
9 33 private unsubsidized, affordable, qualified health
9 34 care coverage to all Iowa children less than nineteen
9 35 years of age with a family income that is more three
9 36 hundred percent of the federal poverty level and to
9 37 adults and families who are not otherwise eligible for
9 38 health care coverage through public programs.

9 39 3. As part of the comprehensive plan developed,
9 40 the association, in consultation with the advisory
9 41 council, shall define what constitutes qualified
9 42 health care coverage for children less than nineteen
9 43 years of age. For the purposes of this definition and
9 44 for designing health care coverage options for
9 45 children, the association, in consultation with the
9 46 advisory council, shall recommend the benefits to be
9 47 included in such coverage and shall explore the value
9 48 of including coverage for the treatment of mental and
9 49 behavioral disorders. The association and the
9 50 advisory council shall perform a cost analysis as part
10 1 of their consideration of benefit options. The
10 2 association and the advisory council shall also
10 3 consider whether to include coverage of the following
10 4 benefits:

- 10 5 a. Inpatient hospital services including medical,
10 6 surgical, intensive care unit, mental health, and
10 7 substance abuse services.
- 10 8 b. Nursing care services including skilled nursing
10 9 facility services.
- 10 10 c. Outpatient hospital services including
10 11 emergency room, surgery, lab, and x-ray services and
10 12 other services.
- 10 13 d. Physician services, including surgical and
10 14 medical, office visits, newborn care, well=baby and
10 15 well=child care, immunizations, urgent care,
10 16 specialist care, allergy testing and treatment, mental
10 17 health visits, and substance abuse visits.
- 10 18 e. Ambulance services.
- 10 19 f. Physical therapy.
- 10 20 g. Speech therapy.
- 10 21 h. Durable medical equipment.
- 10 22 i. Home health care.
- 10 23 j. Hospice services.
- 10 24 k. Prescription drugs.
- 10 25 l. Dental services including preventive services.
- 10 26 m. Medically necessary hearing services.
- 10 27 n. Vision services including corrective lenses.
- 10 28 o. No underwriting requirements and no preexisting
10 29 condition exclusions.

10 30 p. Chiropractic services.
10 31 4. As part of the comprehensive plan developed,
10 32 the association, in consultation with the advisory
10 33 council, shall consider and recommend whether health
10 34 care coverage options that are developed for purchase
10 35 for children less than nineteen years of age with a
10 36 family income that is more than three hundred percent
10 37 of the federal poverty level should require a
10 38 copayment for services received in an amount
10 39 determined by the association.
10 40 5. As part of the comprehensive plan, the
10 41 association, in consultation with the advisory
10 42 council, shall define what constitutes qualified
10 43 health care coverage for adults and families who are
10 44 not eligible for a public program. The association,
10 45 in consultation with the advisory council, shall
10 46 develop and recommend health care coverage options for
10 47 purchase by such adults and families that provide a
10 48 selection of health benefit plans and standardized
10 49 benefits.
10 50 6. As part of the comprehensive plan the
11 1 association and the advisory council may collaborate
11 2 with health insurance carriers to do the following,
11 3 including but not limited to:
11 4 a. Design solutions to issues relating to
11 5 guaranteed issuance of insurance, preexisting
11 6 condition exclusions, portability, and allowable
11 7 pooling and rating classifications.
11 8 b. Formulate principles that ensure fair and
11 9 appropriate practices relating to issues involving
11 10 individual health care policies such as rescission and
11 11 preexisting condition clauses, and that provide for a
11 12 binding third-party review process to resolve disputes
11 13 related to such issues.
11 14 c. Design affordable, portable health care
11 15 coverage options for low-income children, adults, and
11 16 families.
11 17 d. Design a proposed premium schedule for health
11 18 care coverage options that are recommended which
11 19 include the development of rating factors that are
11 20 consistent with market conditions.
11 21 e. Design protocols to limit the transfer from
11 22 employer-sponsored or other private health care
11 23 coverage to state-developed health care coverage
11 24 plans.
11 25 7. The association shall submit the comprehensive
11 26 plan required by this section to the governor and the
11 27 general assembly by December 15, 2008. The
11 28 appropriations to cover children under the medical
11 29 assistance, hawk=i, and hawk=i expansion programs as
11 30 provided in this Act and to provide related outreach
11 31 for fiscal year 2009=2010 and fiscal year 2010=2011
11 32 are contingent upon enactment of a comprehensive plan
11 33 during the 2009 regular session of the Eighty-third
11 34 General Assembly that provides health care coverage
11 35 for all children in the state. Enactment of a
11 36 comprehensive plan shall include a determination of
11 37 what the prospects are of federal action which may
11 38 impact the comprehensive plan and the fiscal impact of
11 39 the comprehensive plan on the state budget.
11 40 Sec. 20. NEW SECTION. 514E.6 IOWA CHOICE HEALTH
11 41 CARE COVERAGE ADVISORY COUNCIL.
11 42 1. The Iowa choice health care coverage advisory
11 43 council is created for the purpose of assisting the
11 44 association with developing a comprehensive health
11 45 care coverage plan as provided in section 514E.5. The
11 46 advisory council shall make recommendations concerning
11 47 the design and implementation of the comprehensive
11 48 plan including but not limited to a definition of what
11 49 constitutes qualified health care coverage,
11 50 suggestions for the design of health care coverage
12 1 options, and implementation of a health care coverage
12 2 reporting requirement.
12 3 2. The advisory council consists of the following
12 4 persons who are voting members unless otherwise
12 5 provided:
12 6 a. The two most recent former governors, or if one
12 7 or both of them are unable or unwilling to serve, a
12 8 person or persons appointed by the governor.
12 9 b. Six members appointed by the director of public
12 10 health:

12 11 (1) A representative of the federation of Iowa
 12 12 insurers.
 12 13 (2) A health economist who resides in Iowa.
 12 14 (3) Two consumers, one of whom shall be a
 12 15 representative of a children's advocacy organization
 12 16 and one of whom shall be a member of a minority.
 12 17 (4) A representative of organized labor.
 12 18 (5) A representative of an organization of
 12 19 employers.
 12 20 c. The following members shall be ex officio,
 12 21 nonvoting members of the council:
 12 22 (1) The commissioner of insurance, or a designee.
 12 23 (2) The director of human services, or a designee.
 12 24 (3) The director of public health, or a designee.
 12 25 (4) Four members of the general assembly, one
 12 26 appointed by the speaker of the house of
 12 27 representatives, one appointed by the minority leader
 12 28 of the house of representatives, one appointed by the
 12 29 majority leader of the senate, and one appointed by
 12 30 the minority leader of the senate.
 12 31 3. The members of the council appointed by the
 12 32 governor shall be appointed for terms of six years
 12 33 beginning and ending as provided in section 69.19.
 12 34 Such a member of the board is eligible for
 12 35 reappointment. The governor shall fill a vacancy for
 12 36 the remainder of the unexpired term.
 12 37 4. The members of the council shall annually elect
 12 38 one voting member as chairperson and one as vice
 12 39 chairperson. Meetings of the council shall be held at
 12 40 the call of the chairperson or at the request of a
 12 41 majority of the council's members.
 12 42 5. The members of the council shall not receive
 12 43 compensation for the performance of their duties as
 12 44 members but each member shall be paid necessary
 12 45 expenses while engaged in the performance of duties of
 12 46 the council. Any legislative member shall be paid the
 12 47 per diem and expenses specified in section 2.10.
 12 48 6. The members of the council are subject to and
 12 49 are officials within the meaning of chapter 68B.

12 50 DIVISION IV

13 1 HEALTH INSURANCE OVERSIGHT

13 2 Sec. 21. Section 505.8, Code Supplement 2007, is
 13 3 amended by adding the following new subsection:
 13 4 NEW SUBSECTION. 5A. The commissioner shall have
 13 5 regulatory authority over health benefit plans and
 13 6 adopt rules under chapter 17A as necessary, to promote
 13 7 the uniformity, cost efficiency, transparency, and
 13 8 fairness of such plans for physicians licensed under
 13 9 chapters 148, 150, and 150A, and hospitals licensed
 13 10 under chapter 135B, for the purpose of maximizing
 13 11 administrative efficiencies and minimizing
 13 12 administrative costs of health care providers and
 13 13 health insurers.

13 14 Sec. 22. HEALTH INSURANCE OVERSIGHT ==
 13 15 APPROPRIATION. There is appropriated from the general
 13 16 fund of the state to the insurance division of the
 13 17 department of commerce for the fiscal year beginning
 13 18 July 1, 2008, and ending June 30, 2009, the following
 13 19 amount, or so much thereof as is necessary, for the
 13 20 purpose designated:

13 21 For identification and regulation of procedures and
 13 22 practices related to health care as provided in
 13 23 section 505.8, subsection 5A:

13 24 \$ 80,000

13 25 DIVISION V

13 26 IOWA HEALTH INFORMATION TECHNOLOGY SYSTEM

13 27 DIVISION XXI

13 28 IOWA HEALTH INFORMATION TECHNOLOGY SYSTEM

13 29 Sec. 23. NEW SECTION. 135.154 DEFINITIONS.

13 30 As used in this division, unless the context
 13 31 otherwise requires:

13 32 1. "Board" means the state board of health created
 13 33 pursuant to section 136.1.

13 34 2. "Department" means the department of public
 13 35 health.

13 36 3. "Health care professional" means a person who
 13 37 is licensed, certified, or otherwise authorized or
 13 38 permitted by the law of this state to administer
 13 39 health care in the ordinary course of business or in
 13 40 the practice of a profession.

13 41 4. "Health information technology" means the

13 42 application of information processing, involving both
13 43 computer hardware and software, that deals with the
13 44 storage, retrieval, sharing, and use of health care
13 45 information, data, and knowledge for communication,
13 46 decision making, quality, safety, and efficiency of
13 47 clinical practice, and may include but is not limited
13 48 to:

13 49 a. An electronic health record that electronically
13 50 compiles and maintains health information that may be
14 1 derived from multiple sources about the health status
14 2 of an individual and may include a core subset of each
14 3 care delivery organization's electronic medical record
14 4 such as a continuity of care record or a continuity of
14 5 care document, computerized physician order entry,
14 6 electronic prescribing, or clinical decision support.

14 7 b. A personal health record through which an
14 8 individual and any other person authorized by the
14 9 individual can maintain and manage the individual's
14 10 health information.

14 11 c. An electronic medical record that is used by
14 12 health care professionals to electronically document,
14 13 monitor, and manage health care delivery within a care
14 14 delivery organization, is the legal record of the
14 15 patient's encounter with the care delivery
14 16 organization, and is owned by the care delivery
14 17 organization.

14 18 d. A computerized provider order entry function
14 19 that permits the electronic ordering of diagnostic and
14 20 treatment services, including prescription drugs.

14 21 e. A decision support function to assist
14 22 physicians and other health care providers in making
14 23 clinical decisions by providing electronic alerts and
14 24 reminders to improve compliance with best practices,
14 25 promote regular screenings and other preventive
14 26 practices, and facilitate diagnoses and treatments.

14 27 f. Tools to allow for the collection, analysis,
14 28 and reporting of information or data on adverse
14 29 events, the quality and efficiency of care, patient
14 30 satisfaction, and other health care-related
14 31 performance measures.

14 32 5. "Interoperability" means the ability of two or
14 33 more systems or components to exchange information or
14 34 data in an accurate, effective, secure, and consistent
14 35 manner and to use the information or data that has
14 36 been exchanged and includes but is not limited to:

14 37 a. The capacity to connect to a network for the
14 38 purpose of exchanging information or data with other
14 39 users.

14 40 b. The ability of a connected, authenticated user
14 41 to demonstrate appropriate permissions to participate
14 42 in the instant transaction over the network.

14 43 c. The capacity of a connected, authenticated user
14 44 to access, transmit, receive, and exchange usable
14 45 information with other users.

14 46 6. "Recognized interoperability standard" means
14 47 interoperability standards recognized by the office of
14 48 the national coordinator for health information
14 49 technology of the United States department of health
14 50 and human services.

15 1 Sec. 24. NEW SECTION. 135.155 IOWA ELECTRONIC
15 2 HEALTH == PRINCIPLES == GOALS.

15 3 1. Health information technology is rapidly
15 4 evolving so that it can contribute to the goals of
15 5 improving access to and quality of health care,
15 6 enhancing efficiency, and reducing costs.

15 7 2. To be effective, the health information
15 8 technology system shall comply with all of the
15 9 following principles:

15 10 a. Be patient-centered and market-driven.

15 11 b. Be based on approved standards developed with
15 12 input from all stakeholders.

15 13 c. Protect the privacy of consumers and the
15 14 security and confidentiality of all health
15 15 information.

15 16 d. Promote interoperability.

15 17 e. Ensure the accuracy, completeness, and
15 18 uniformity of data.

15 19 3. Widespread adoption of health information
15 20 technology is critical to a successful health
15 21 information technology system and is best achieved
15 22 when all of the following occur:

15 23 a. The market provides a variety of certified
15 24 products from which to choose in order to best fit the
15 25 needs of the user.

15 26 b. The system provides incentives for health care
15 27 professionals to utilize the health information
15 28 technology and provides rewards for any improvement in
15 29 quality and efficiency resulting from such
15 30 utilization.

15 31 c. The system provides protocols to address
15 32 critical problems.

15 33 d. The system is financed by all who benefit from
15 34 the improved quality, efficiency, savings, and other
15 35 benefits that result from use of health information
15 36 technology.

15 37 Sec. 25. NEW SECTION. 135.156 ELECTRONIC HEALTH
15 38 INFORMATION == DEPARTMENT DUTIES == ADVISORY COUNCIL
15 39 == EXECUTIVE COMMITTEE.

15 40 1. a. The department shall direct a public and
15 41 private collaborative effort to promote the adoption
15 42 and use of health information technology in this state
15 43 in order to improve health care quality, increase
15 44 patient safety, reduce health care costs, enhance
15 45 public health, and empower individuals and health care
15 46 professionals with comprehensive, real-time medical
15 47 information to provide continuity of care and make the
15 48 best health care decisions. The department shall
15 49 provide coordination for the development and
15 50 implementation of an interoperable electronic health
16 1 records system, telehealth expansion efforts, the
16 2 health information technology infrastructure, and
16 3 other health information technology initiatives in
16 4 this state. The department shall be guided by the
16 5 principles and goals specified in section 135.155.

16 6 b. All health information technology efforts shall
16 7 endeavor to represent the interests and meet the needs
16 8 of consumers and the health care sector, protect the
16 9 privacy of individuals and the confidentiality of
16 10 individuals' information, promote physician best
16 11 practices, and make information easily accessible to
16 12 the appropriate parties. The system developed shall
16 13 be consumer-driven, flexible, and expandable.

16 14 2. a. An electronic health information advisory
16 15 council is established which shall consist of the
16 16 representatives of entities involved in the electronic
16 17 health records system task force established pursuant
16 18 to section 217.41A, Code 2007, a pharmacist, a
16 19 licensed practicing physician, a consumer who is a
16 20 member of the state board of health, a representative
16 21 of the state's Medicare quality improvement
16 22 organization, the executive director of the Iowa
16 23 communications network, a representative of the
16 24 private telecommunications industry, a representative
16 25 of the Iowa collaborative safety net provider network
16 26 created in section 135.153, a nurse informaticist from
16 27 the university of Iowa, and any other members the
16 28 department or executive committee of the advisory
16 29 council determine necessary to assist the department
16 30 or executive committee at various stages of
16 31 development of the electronic health information
16 32 system. Executive branch agencies shall also be
16 33 included as necessary to assist in the duties of the
16 34 department and the executive committee. Public
16 35 members of the advisory council shall receive
16 36 reimbursement for actual expenses incurred while
16 37 serving in their official capacity only if they are
16 38 not eligible for reimbursement by the organization
16 39 that they represent. Any legislative members shall be
16 40 paid the per diem and expenses specified in section
16 41 2.10.

16 42 b. An executive committee of the electronic health
16 43 information advisory council is established. Members
16 44 of the executive committee of the advisory council
16 45 shall receive reimbursement for actual expenses
16 46 incurred while serving in their official capacity only
16 47 if they are not eligible for reimbursement by the
16 48 organization that they represent. The executive
16 49 committee shall consist of the following members:

16 50 (1) Three members, each of whom is the chief
17 1 information officer of one of the three largest
17 2 private health care systems in the state.

17 3 (2) One member who is a representative of the

17 4 university of Iowa.
17 5 (3) One member who is a representative of a rural
17 6 hospital that is a member of the Iowa hospital
17 7 association.
17 8 (4) One member who is a consumer member of the
17 9 state board of health.
17 10 (5) One member who is a licensed practicing
17 11 physician.
17 12 (6) One member who is a health care provider other
17 13 than a licensed practicing physician.
17 14 (7) A representative of the federation of Iowa
17 15 insurers.

17 16 3. The executive committee, with the technical
17 17 assistance of the advisory council and the support of
17 18 the department shall do all of the following:
17 19 a. Develop a statewide health information
17 20 technology plan by July 1, 2009. In developing the
17 21 plan, the executive committee shall seek the input of
17 22 providers, payers, and consumers. Standards and
17 23 policies developed for the plan shall promote and be
17 24 consistent with national standards developed by the
17 25 office of the national coordinator for health
17 26 information technology of the United States department
17 27 of health and human services and shall address or
17 28 provide for all of the following:
17 29 (1) The effective, efficient, statewide use of
17 30 electronic health information in patient care, health
17 31 care policymaking, clinical research, health care
17 32 financing, and continuous quality improvement. The
17 33 executive committee shall recommend requirements for
17 34 interoperable electronic health records in this state
17 35 including a recognized interoperability standard.
17 36 (2) Education of the public and health care sector
17 37 about the value of health information technology in
17 38 improving patient care, and methods to promote
17 39 increased support and collaboration of state and local
17 40 public health agencies, health care professionals, and
17 41 consumers in health information technology
17 42 initiatives.
17 43 (3) Standards for the exchange of health care
17 44 information.
17 45 (4) Policies relating to the protection of privacy
17 46 of patients and the security and confidentiality of
17 47 patient information.
17 48 (5) Policies relating to information ownership.
17 49 (6) Policies relating to governance of the various
17 50 facets of the health information technology system.
18 1 (7) A single patient identifier or alternative
18 2 mechanism to share secure patient information. If no
18 3 alternative mechanism is acceptable to the executive
18 4 committee, all health care professionals shall utilize
18 5 the mechanism selected by the executive committee by
18 6 July 1, 2010.
18 7 (8) A standard continuity of care record and other
18 8 issues related to the content of electronic
18 9 transmissions. All health care professionals shall
18 10 utilize the standard continuity of care record by July
18 11 1, 2010.
18 12 (9) Requirements for electronic prescribing.
18 13 (10) Economic incentives and support to facilitate
18 14 participation in an interoperable system by health
18 15 care professionals.

18 16 b. Identify existing and potential health
18 17 information technology efforts in this state,
18 18 regionally, and nationally, and integrate existing
18 19 efforts to avoid incompatibility between efforts and
18 20 avoid duplication.

18 21 c. Coordinate public and private efforts to
18 22 provide the network backbone infrastructure for the
18 23 health information technology system. In coordinating
18 24 these efforts, the executive committee shall do all of
18 25 the following:
18 26 (1) Develop policies to effectuate the logical
18 27 cost-effective usage of and access to the state-owned
18 28 network, and support of telecommunication carrier
18 29 products, where applicable.
18 30 (2) Consult with the Iowa communications network,
18 31 private fiberoptic networks, and any other
18 32 communications entity to seek collaboration, avoid
18 33 duplication, and leverage opportunities in developing
18 34 a backbone network.

18 35 (3) Establish protocols to ensure compliance with
18 36 any applicable federal standards.

18 37 (4) Determine costs for accessing the network at a
18 38 level that provides sufficient funding for the
18 39 network.

18 40 d. Promote the use of telemedicine.

18 41 (1) Examine existing barriers to the use of
18 42 telemedicine and make recommendations for eliminating
18 43 these barriers.

18 44 (2) Examine the most efficient and effective
18 45 systems of technology for use and make recommendations
18 46 based on the findings.

18 47 e. Address the workforce needs generated by
18 48 increased use of health information technology.

18 49 f. Recommend rules to be adopted in accordance
18 50 with chapter 17A to implement all aspects of the
19 1 statewide health information technology plan and the
19 2 network.

19 3 g. Coordinate, monitor, and evaluate the adoption,
19 4 use, interoperability, and efficiencies of the various
19 5 facets of health information technology in this state.

19 6 h. Seek and apply for any federal or private
19 7 funding to assist in the implementation and support of
19 8 the health information technology system and make
19 9 recommendations for funding mechanisms for the ongoing
19 10 development and maintenance costs of the health
19 11 information technology system.

19 12 i. Identify state laws and rules that present
19 13 barriers to the development of the health information
19 14 technology system and recommend any changes to the
19 15 governor and the general assembly.

19 16 4. Recommendations and other activities resulting
19 17 from the work of the executive committee shall be
19 18 presented to the board for action or implementation.

19 19 Sec. 26. Section 8D.13, Code 2007, is amended by
19 20 adding the following new subsection:

19 21 NEW SUBSECTION. 20. Access shall be offered to
19 22 the Iowa hospital association only for the purposes of
19 23 collection, maintenance, and dissemination of health
19 24 and financial data for hospitals and for hospital
19 25 education services. The Iowa hospital association
19 26 shall be responsible for all costs associated with
19 27 becoming part of the network, as determined by the
19 28 commission.

19 29 Sec. 27. Section 136.3, Code 2007, is amended by
19 30 adding the following new subsection:

19 31 NEW SUBSECTION. 11. Perform those duties
19 32 authorized pursuant to section 135.156.

19 33 Sec. 28. Section 217.41A, Code 2007, is repealed.

19 34 Sec. 29. IOWA HEALTH INFORMATION TECHNOLOGY SYSTEM
19 35 == APPROPRIATION. There is appropriated from the
19 36 general fund of the state to the department of public
19 37 health for the fiscal year beginning July 1, 2008, and
19 38 ending June 30, 2009, the following amount, or so much
19 39 thereof as is necessary, for the purpose designated:

19 40 For administration of the Iowa health information
19 41 technology system, and for not more than the following
19 42 full-time equivalent positions:

19 43	\$	190,600
19 44	FTEs	2.00

19 45 DIVISION VI
19 46 LONG-TERM LIVING PLANNING AND
19 47 PATIENT AUTONOMY IN HEALTH CARE

19 48 Sec. 30. NEW SECTION. 231.62 END-OF-LIFE CARE
19 49 INFORMATION.

19 50 1. The department shall consult with the Iowa
20 1 medical society, the Iowa end-of-life coalition, the
20 2 Iowa hospice organization, the university of Iowa
20 3 palliative care program, and other health care
20 4 professionals whose scope of practice includes
20 5 end-of-life care to develop educational and
20 6 patient-centered information on end-of-life care for
20 7 terminally ill patients and health care professionals.

20 8 2. For the purposes of this section, "end-of-life
20 9 care" means care provided to meet the physical,
20 10 psychological, social, spiritual, and practical needs
20 11 of terminally ill patients and their caregivers.

20 12 Sec. 31. END-OF-LIFE CARE INFORMATION ==
20 13 APPROPRIATION. There is appropriated from the general
20 14 fund of the state to the department of elder affairs
20 15 for the fiscal year beginning July 1, 2008, and ending

20 16 June 30, 2009, the following amount, or so much
20 17 thereof as is necessary, for the purpose designated:
20 18 For activities associated with the end-of-life care
20 19 information requirements of this division:
20 20 \$ 10,000

20 21 Sec. 32. LONG-TERM LIVING PLANNING TOOLS == PUBLIC
20 22 EDUCATION CAMPAIGN. The legal services development
20 23 and substitute decision maker programs of the
20 24 department of elder affairs, in collaboration with
20 25 other appropriate agencies and interested parties,
20 26 shall research existing long-term living planning
20 27 tools that are designed to increase quality of life
20 28 and contain health care costs and recommend a public
20 29 education campaign strategy on long-term living to the
20 30 general assembly by January 1, 2009.

20 31 Sec. 33. LONG-TERM CARE OPTIONS PUBLIC EDUCATION
20 32 CAMPAIGN. The department of elder affairs, in
20 33 collaboration with the insurance division of the
20 34 department of commerce, shall implement a long-term
20 35 care options public education campaign. The campaign
20 36 may utilize such tools as the "Own Your Future
20 37 Planning Kit" administered by the centers for Medicare
20 38 and Medicaid services, the administration on aging,
20 39 and the office of the assistant secretary for planning
20 40 and evaluation of the United States department of
20 41 health and human services, and other tools developed
20 42 through the aging and disability resource center
20 43 program of the administration on aging and the centers
20 44 for Medicare and Medicaid services designed to promote
20 45 health and independence as Iowans age, assist older
20 46 Iowans in making informed choices about the
20 47 availability of long-term care options, including
20 48 alternatives to facility-based care, and to streamline
20 49 access to long-term care.

20 50 Sec. 34. LONG-TERM CARE OPTIONS PUBLIC EDUCATION
21 1 CAMPAIGN == APPROPRIATION. There is appropriated from
21 2 the general fund of the state to the department of
21 3 elder affairs for the fiscal year beginning July 1,
21 4 2008, and ending June 30, 2009, the following amount,
21 5 or so much thereof as is necessary, for the purpose
21 6 designated:

21 7 For activities associated with the long-term care
21 8 options public education campaign requirements of this
21 9 division:
21 10 \$ 75,000

21 11 Sec. 35. HOME AND COMMUNITY-BASED SERVICES PUBLIC
21 12 EDUCATION CAMPAIGN. The department of elder affairs
21 13 shall work with other public and private agencies to
21 14 identify resources that may be used to continue the
21 15 work of the aging and disability resource center
21 16 established by the department through the aging and
21 17 disability resource center grant program efforts of
21 18 the administration on aging and the centers for
21 19 Medicare and Medicaid services of the United States
21 20 department of health and human services, beyond the
21 21 federal grant period ending September 30, 2008.

21 22 Sec. 36. PATIENT AUTONOMY IN HEALTH CARE DECISIONS
21 23 PILOT PROJECT.

21 24 1. The department of public health shall establish
21 25 a two-year community coalition for patient treatment
21 26 wishes across the health care continuum pilot project,
21 27 beginning July 1, 2008, and ending June 30, 2010, in a
21 28 county with a population of between fifty thousand and
21 29 one hundred thousand. The pilot project shall utilize
21 30 the process based upon the national physicians orders
21 31 for life sustaining treatment program initiative,
21 32 including use of a standardized physician order for
21 33 scope of treatment form. The process shall require
21 34 validation of the physician order for scope of
21 35 treatment form by the signature of an individual other
21 36 than the patient or the patient's legal representative
21 37 who is not an employee of the patient's physician.
21 38 The pilot project may include applicability to
21 39 chronically ill, frail, and elderly or terminally ill
21 40 individuals in hospitals licensed pursuant to chapter
21 41 135B, nursing facilities or residential care
21 42 facilities licensed pursuant to chapter 135C, or
21 43 hospice programs as defined in section 135J.1.

21 44 2. The department of public health shall convene
21 45 an advisory council, consisting of representatives of
21 46 entities with interest in the pilot project, including

21 47 but not limited to the Iowa hospital association, the
21 48 Iowa medical society, organizations representing
21 49 health care facilities, representatives of health care
21 50 providers, and the Iowa trial lawyers association, to
22 1 develop recommendations for expanding the pilot
22 2 project statewide. The advisory council shall report
22 3 its findings and recommendations, including
22 4 recommendations for legislation, to the governor and
22 5 the general assembly by January 1, 2010.

22 6 3. The pilot project shall not alter the rights of
22 7 individuals who do not execute a physician order for
22 8 scope of treatment.

22 9 a. If an individual is a qualified patient as
22 10 defined in section 144A.2, the individual's
22 11 declaration executed under chapter 144A shall control
22 12 health care decision making for the individual in
22 13 accordance with chapter 144A. A physician order for
22 14 scope of treatment shall not supersede a declaration
22 15 executed pursuant to chapter 144A. If an individual
22 16 has not executed a declaration pursuant to chapter
22 17 144A, health care decision making relating to
22 18 life=sustaining procedures for the individual shall be
22 19 governed by section 144A.7.

22 20 b. If an individual has executed a durable power
22 21 of attorney for health care pursuant to chapter 144B,
22 22 the individual's durable power of attorney for health
22 23 care shall control health care decision making for the
22 24 individual in accordance with chapter 144B. A
22 25 physician order for scope of treatment shall not
22 26 supersede a durable power of attorney for health care
22 27 executed pursuant to chapter 144B.

22 28 c. In the absence of actual notice of the
22 29 revocation of a physician order for scope of
22 30 treatment, a physician, health care provider, or any
22 31 other person who complies with a physician order for
22 32 scope of treatment shall not be subject to liability,
22 33 civil or criminal, for actions taken under this
22 34 section which are in accordance with reasonable
22 35 medical standards. Any physician, health care
22 36 provider, or other person against whom criminal or
22 37 civil liability is asserted because of conduct in
22 38 compliance with this section may interpose the
22 39 restriction on liability in this paragraph as an
22 40 absolute defense.

22 41 DIVISION VII

22 42 HEALTH CARE COVERAGE

22 43 Sec. 37. NEW SECTION. 505.31 REIMBURSEMENT
22 44 ACCOUNTS.

22 45 The commissioner of insurance shall assist
22 46 employers with twenty=five or fewer employees with
22 47 implementing and administering plans under section 125
22 48 of the Internal Revenue Code, including medical
22 49 expense reimbursement accounts and dependent care
22 50 accounts. The commissioner shall provide information
23 1 about the assistance available to small employers on
23 2 the insurance division's internet site.

23 3 Sec. 38. Section 509.3, Code 2007, is amended by
23 4 adding the following new subsection:

23 5 NEW SUBSECTION. 8. A provision that the insurer
23 6 will permit continuation of existing coverage for an
23 7 unmarried child of an insured or enrollee who so
23 8 elects, at least through the policy anniversary date
23 9 on or after the date the child marries, ceases to be a
23 10 resident of this state, or attains the age of
23 11 twenty=five years old, whichever occurs first, or so
23 12 long as the unmarried child maintains full=time status
23 13 as a student in an accredited institution of
23 14 postsecondary education.

23 15 Sec. 39. NEW SECTION. 509A.13B CONTINUATION OF
23 16 DEPENDENT COVERAGE.

23 17 If a governing body, a county board of supervisors,
23 18 or a city council has procured accident or health care
23 19 coverage for its employees under this chapter such
23 20 coverage shall permit continuation of existing
23 21 coverage for an unmarried child of an insured or
23 22 enrollee who so elects, at least through the policy
23 23 anniversary date on or after the date the child
23 24 marries, ceases to be a resident of this state, or
23 25 attains the age of twenty=five years old, whichever
23 26 occurs first, or so long as the unmarried child
23 27 maintains full=time status as a student in an

23 28 accredited institution of postsecondary education.
23 29 Sec. 40. Section 513C.7, subsection 2, paragraph
23 30 a, Code 2007, is amended to read as follows:
23 31 ~~a-~~ The individual basic or standard health benefit
23 32 plan shall not deny, exclude, or limit benefits for a
23 33 covered individual for losses incurred more than
23 34 twelve months following the effective date of the
23 35 individual's coverage due to a preexisting condition.
23 36 A preexisting condition shall not be defined more
23 37 restrictively than any of the following:

23 38 (1) ~~a.~~ A condition that would cause an ordinarily
23 39 prudent person to seek medical advice, diagnosis,
23 40 care, or treatment during the twelve months
23 41 immediately preceding the effective date of coverage.

23 42 (2) ~~b.~~ A condition for which medical advice,
23 43 diagnosis, care, or treatment was recommended or
23 44 received during the twelve months immediately
23 45 preceding the effective date of coverage.

23 46 (3) ~~c.~~ A pregnancy existing on the effective date
23 47 of coverage.

23 48 Sec. 41. Section 513C.7, subsection 2, paragraph
23 49 b, Code 2007, is amended by striking the paragraph.

23 50 Sec. 42. NEW SECTION. 514A.3B ADDITIONAL

24 1 REQUIREMENTS.

24 2 1. An insurer which accepts an individual for
24 3 coverage under an individual policy or contract of
24 4 accident and health insurance shall waive any time
24 5 period applicable to a preexisting condition exclusion
24 6 or limitation period requirement of the policy or
24 7 contract with respect to particular services in an
24 8 individual health benefit plan for the period of time
24 9 the individual was previously covered by qualifying
24 10 previous coverage as defined in section 513C.3 that
24 11 provided benefits with respect to such services,
24 12 provided that the qualifying previous coverage was
24 13 continuous to a date not more than sixty-three days
24 14 prior to the effective date of the new policy or
24 15 contract. For purposes of this section, periods of
24 16 coverage under medical assistance provided pursuant to
24 17 chapter 249A or 514I, or Medicare coverage provided
24 18 pursuant to Title XVIII of the federal Social Security
24 19 Act shall not be counted with respect to the
24 20 sixty-three-day requirement.

24 21 2. An insurer issuing an individual policy or
24 22 contract of accident and health insurance which
24 23 provides coverage for children of the insured shall
24 24 permit continuation of existing coverage for an
24 25 unmarried child of an insured or enrollee who so
24 26 elects, at least through the policy anniversary date
24 27 on or after the date the child marries, ceases to be a
24 28 resident of this state, or attains the age of
24 29 twenty-five years old, whichever occurs first, or so
24 30 long as the unmarried child maintains full-time status
24 31 as a student in an accredited institution of
24 32 postsecondary education.

24 33 Sec. 43. APPLICABILITY. This division of this Act
24 34 applies to policies or contracts of accident and
24 35 health insurance delivered or issued for delivery or
24 36 continued or renewed in this state on or after July 1,
24 37 2008.

24 38 DIVISION VIII

24 39 MEDICAL HOME

24 40 DIVISION XXII

24 41 MEDICAL HOME

24 42 Sec. 44. NEW SECTION. 135.157 DEFINITIONS.

24 43 As used in this chapter, unless the context
24 44 otherwise requires:

24 45 1. "Board" means the state board of health created
24 46 pursuant to section 136.1.

24 47 2. "Department" means the department of public
24 48 health.

24 49 3. "Health care professional" means a person who
24 50 is licensed, certified, or otherwise authorized or
25 1 permitted by the law of this state to administer
25 2 health care in the ordinary course of business or in
25 3 the practice of a profession.

25 4 4. "Medical home" means a team approach to
25 5 providing health care that originates in a primary
25 6 care setting; fosters a partnership among the patient,
25 7 the personal provider, and other health care
25 8 professionals, and where appropriate, the patient's

25 9 family; utilizes the partnership to access all medical
25 10 and nonmedical health-related services needed by the
25 11 patient and the patient's family to achieve maximum
25 12 health potential; maintains a centralized,
25 13 comprehensive record of all health-related services to
25 14 promote continuity of care; and has all of the
25 15 characteristics specified in section 135.158.

25 16 5. "National committee for quality assurance"
25 17 means the nationally recognized, independent nonprofit
25 18 organization that measures the quality and performance
25 19 of health care and health care plans in the United
25 20 States; provides accreditation, certification, and
25 21 recognition programs for health care plans and
25 22 programs; and is recognized in Iowa as an accrediting
25 23 organization for commercial and Medicaid-managed care
25 24 organizations.

25 25 6. "Personal provider" means the patient's first
25 26 point of contact in the health care system with a
25 27 primary care provider who identifies the patient's
25 28 health needs, and, working with a team of health care
25 29 professionals, provides for and coordinates
25 30 appropriate care to address the health needs
25 31 identified.

25 32 7. "Primary care" means health care which
25 33 emphasizes providing for a patient's general health
25 34 needs and utilizes collaboration with other health
25 35 care professionals and consultation or referral as
25 36 appropriate to meet the needs identified.

25 37 8. "Primary care provider" means any of the
25 38 following who provide primary care and meet
25 39 certification standards:

25 40 a. A physician who is a family or general
25 41 practitioner, a pediatrician, an internist, an
25 42 obstetrician, or a gynecologist.

25 43 b. An advanced registered nurse practitioner.

25 44 c. A physician assistant.

25 45 d. A chiropractor licensed pursuant to chapter
25 46 151.

25 47 Sec. 45. NEW SECTION. 135.158 MEDICAL HOME
25 48 PURPOSES == CHARACTERISTICS.

25 49 1. The purposes of a medical home are the
25 50 following:

26 1 a. To reduce disparities in health care access,
26 2 delivery, and health care outcomes.

26 3 b. To improve quality of health care and lower
26 4 health care costs, thereby creating savings to allow
26 5 more Iowans to have health care coverage and to
26 6 provide for the sustainability of the health care
26 7 system.

26 8 c. To provide a tangible method to document if
26 9 each Iowan has access to health care.

26 10 2. A medical home has all of the following
26 11 characteristics:

26 12 a. A personal provider. Each patient has an
26 13 ongoing relationship with a personal provider trained
26 14 to provide first contact and continuous and
26 15 comprehensive care.

26 16 b. A provider-directed medical practice. The
26 17 personal provider leads a team of individuals at the
26 18 practice level who collectively take responsibility
26 19 for the ongoing health care of patients.

26 20 c. Whole person orientation. The personal
26 21 provider is responsible for providing for all of a
26 22 patient's health care needs or taking responsibility
26 23 for appropriately arranging health care by other
26 24 qualified health care professionals. This
26 25 responsibility includes health care at all stages of
26 26 life including provision of acute care, chronic care,
26 27 preventive services, and end-of-life care.

26 28 d. Coordination and integration of care. Care is
26 29 coordinated and integrated across all elements of the
26 30 complex health care system and the patient's
26 31 community. Care is facilitated by registries,
26 32 information technology, health information exchanges,
26 33 and other means to assure that patients receive the
26 34 indicated care when and where they need and want the
26 35 care in a culturally and linguistically appropriate
26 36 manner.

26 37 e. Quality and safety. The following are quality
26 38 and safety components of the medical home:

26 39 (1) Provider-directed medical practices advocate

26 40 for their patients to support the attainment of
26 41 optimal, patient-centered outcomes that are defined by
26 42 a care planning process driven by a compassionate,
26 43 robust partnership between providers, the patient, and
26 44 the patient's family.

26 45 (2) Evidence-based medicine and clinical
26 46 decision-support tools guide decision making.

26 47 (3) Providers in the medical practice accept
26 48 accountability for continuous quality improvement
26 49 through voluntary engagement in performance
26 50 measurement and improvement.

27 1 (4) Patients actively participate in decision
27 2 making and feedback is sought to ensure that the
27 3 patients' expectations are being met.

27 4 (5) Information technology is utilized
27 5 appropriately to support optimal patient care,
27 6 performance measurement, patient education, and
27 7 enhanced communication.

27 8 (6) Practices participate in a voluntary
27 9 recognition process conducted by an appropriate
27 10 nongovernmental entity to demonstrate that the
27 11 practice has the capabilities to provide
27 12 patient-centered services consistent with the medical
27 13 home model.

27 14 (7) Patients and families participate in quality
27 15 improvement activities at the practice level.

27 16 f. Enhanced access to health care. Enhanced
27 17 access to health care is available through systems
27 18 such as open scheduling, expanded hours, and new
27 19 options for communication between the patient, the
27 20 patient's personal provider, and practice staff.

27 21 g. Payment. The payment system appropriately
27 22 recognizes the added value provided to patients who
27 23 have a patient-centered medical home. The payment
27 24 structure framework of the medical home provides all
27 25 of the following:

27 26 (1) Reflects the value of provider and nonprovider
27 27 staff and patient-centered care management work that
27 28 is in addition to the face-to-face visit.

27 29 (2) Pays for services associated with coordination
27 30 of health care both within a given practice and
27 31 between consultants, ancillary providers, and
27 32 community resources.

27 33 (3) Supports adoption and use of health
27 34 information technology for quality improvement.

27 35 (4) Supports provision of enhanced communication
27 36 access such as secure electronic mail and telephone
27 37 consultation.

27 38 (5) Recognizes the value of provider work
27 39 associated with remote monitoring of clinical data
27 40 using technology.

27 41 (6) Allows for separate fee-for-service payments
27 42 for face-to-face visits. Payments for health care
27 43 management services that are in addition to the
27 44 face-to-face visit do not result in a reduction in the
27 45 payments for face-to-face visits.

27 46 (7) Recognizes case mix differences in the patient
27 47 population being treated within the practice.

27 48 (8) Allows providers to share in savings from
27 49 reduced hospitalizations associated with
27 50 provider-guided health care management in the office
28 1 setting.

28 2 (9) Allows for additional payments for achieving
28 3 measurable and continuous quality improvements.

28 4 Sec. 46. NEW SECTION. 135.159 MEDICAL HOME
28 5 SYSTEM == ADVISORY COUNCIL == DEVELOPMENT AND
28 6 IMPLEMENTATION.

28 7 1. The department shall administer the medical
28 8 home system. The department shall adopt rules
28 9 pursuant to chapter 17A necessary to administer the
28 10 medical home system.

28 11 2. a. The department shall establish an advisory
28 12 council which shall include but is not limited to all
28 13 of the following members, selected by their respective
28 14 organizations, and any other members the department
28 15 determines necessary to assist in the department's
28 16 duties at various stages of development of the medical
28 17 home system:

28 18 (1) The director of human services, or the
28 19 director's designee.

28 20 (2) The commissioner of insurance, or the

28 21 commissioner's designee.
28 22 (3) A representative of the federation of Iowa
28 23 insurers.
28 24 (4) A representative of the Iowa dental
28 25 association.
28 26 (5) A representative of the Iowa nurses
28 27 association.
28 28 (6) A physician licensed pursuant to chapter 148
28 29 and a physician licensed pursuant to chapter 150 who
28 30 are family physicians and members of the Iowa academy
28 31 of family physicians.
28 32 (7) A health care consumer.
28 33 (8) A representative of the Iowa collaborative
28 34 safety net provider network established pursuant to
28 35 section 135.153.
28 36 (9) A representative of the governor's
28 37 developmental disabilities council.
28 38 (10) A representative of the Iowa chapter of the
28 39 American academy of pediatrics.
28 40 (11) A representative of the child and family
28 41 policy center.
28 42 (12) A representative of the Iowa pharmacy
28 43 association.
28 44 (13) A representative of the Iowa chiropractic
28 45 society.
28 46 (14) A representative of the university of Iowa
28 47 college of public health.
28 48 b. Public members of the advisory council shall
28 49 receive reimbursement for actual expenses incurred
28 50 while serving in their official capacity only if they
29 1 are not eligible for reimbursement by the organization
29 2 that they represent.
29 3 3. The department shall develop a plan for
29 4 implementation of a statewide medical home system.
29 5 The department, in collaboration with parents,
29 6 schools, communities, health plans, and providers,
29 7 shall endeavor to increase healthy outcomes for
29 8 children and adults by linking the children and adults
29 9 with a medical home, identifying health improvement
29 10 goals for children and adults, and linking
29 11 reimbursement strategies to increasing healthy
29 12 outcomes for children and adults. The plan shall
29 13 provide that the medical home system shall do all of
29 14 the following:
29 15 a. Coordinate and provide access to evidence-based
29 16 health care services, emphasizing convenient,
29 17 comprehensive primary care and including preventive,
29 18 screening, and well-child health services.
29 19 b. Provide access to appropriate specialty care
29 20 and inpatient services.
29 21 c. Provide quality-driven and cost-effective
29 22 health care.
29 23 d. Provide access to pharmacist-delivered
29 24 medication reconciliation and medication therapy
29 25 management services, where appropriate.
29 26 e. Promote strong and effective medical management
29 27 including but not limited to planning treatment
29 28 strategies, monitoring health outcomes and resource
29 29 use, sharing information, and organizing care to avoid
29 30 duplication of service. The plan shall provide that
29 31 in sharing information, the priority shall be the
29 32 protection of the privacy of individuals and the
29 33 security and confidentiality of the individual's
29 34 information. Any sharing of information required by
29 35 the medical home system shall comply and be consistent
29 36 with all existing state and federal laws and
29 37 regulations relating to the confidentiality of health
29 38 care information and shall be subject to written
29 39 consent of the patient.
29 40 f. Emphasize patient and provider accountability.
29 41 g. Prioritize local access to the continuum of
29 42 health care services in the most appropriate setting.
29 43 h. Establish a baseline for medical home goals and
29 44 establish performance measures that indicate a child
29 45 or adult has an established and effective medical
29 46 home. For children, these goals and performance
29 47 measures may include but are not limited to childhood
29 48 immunizations rates, well-child care utilization
29 49 rates, care management for children with chronic
29 50 illnesses, emergency room utilization, and oral health
30 1 service utilization.

30 2 i. For children, coordinate with and integrate
30 3 guidelines, data, and information from existing
30 4 newborn and child health programs and entities,
30 5 including but not limited to the healthy opportunities
30 6 to experience, success=healthy families Iowa program,
30 7 the community empowerment program, the center for
30 8 congenital and inherited disorders screening and
30 9 health care programs, standards of care for pediatric
30 10 health guidelines, the office of multicultural health
30 11 established in section 135.12, the oral health bureau
30 12 established in section 135.15, and other similar
30 13 programs and services.

30 14 4. The department shall develop an organizational
30 15 structure for the medical home system in this state.
30 16 The organizational structure plan shall integrate
30 17 existing resources, provide a strategy to coordinate
30 18 health care services, provide for monitoring and data
30 19 collection on medical homes, provide for training and
30 20 education to health care professionals and families,
30 21 and provide for transition of children to the adult
30 22 medical care system. The organizational structure may
30 23 be based on collaborative teams of stakeholders
30 24 throughout the state such as local public health
30 25 agencies, the collaborative safety net provider
30 26 network established in section 135.153, or a
30 27 combination of statewide organizations. Care
30 28 coordination may be provided through regional offices
30 29 or through individual provider practices. The
30 30 organizational structure may also include the use of
30 31 telemedicine resources, and may provide for partnering
30 32 with pediatric and family practice residency programs
30 33 to improve access to preventive care for children.
30 34 The organizational structure shall also address the
30 35 need to organize and provide health care to increase
30 36 accessibility for patients including using venues more
30 37 accessible to patients and having hours of operation
30 38 that are conducive to the population served.

30 39 5. The department shall adopt standards and a
30 40 process to certify medical homes based on the national
30 41 committee for quality assurance standards. The
30 42 certification process and standards shall provide
30 43 mechanisms to monitor performance and to evaluate,
30 44 promote, and improve the quality of health of and
30 45 health care delivered to patients through a medical
30 46 home. The mechanism shall require participating
30 47 providers to monitor clinical progress and performance
30 48 in meeting applicable standards and to provide
30 49 information in a form and manner specified by the
30 50 department. The evaluation mechanism shall be
31 1 developed with input from consumers, providers, and
31 2 payers. At a minimum the evaluation shall determine
31 3 any increased quality in health care provided and any
31 4 decrease in cost resulting from the medical home
31 5 system compared with other health care delivery
31 6 systems. The standards and process shall also include
31 7 a mechanism for other ancillary service providers to
31 8 become affiliated with a certified medical home.

31 9 6. The department shall adopt education and
31 10 training standards for health care professionals
31 11 participating in the medical home system.

31 12 7. The department shall provide for system
31 13 simplification through the use of universal referral
31 14 forms, internet-based tools for providers, and a
31 15 central medical home internet site for providers.

31 16 8. The department shall recommend a reimbursement
31 17 methodology and incentives for participation in the
31 18 medical home system to ensure that providers enter and
31 19 remain participating in the system. In developing the
31 20 recommendations for incentives, the department shall
31 21 consider, at a minimum, providing incentives to
31 22 promote wellness, prevention, chronic care management,
31 23 immunizations, health care management, and the use of
31 24 electronic health records. In developing the
31 25 recommendations for the reimbursement system, the
31 26 department shall analyze, at a minimum, the
31 27 feasibility of all of the following:

31 28 a. Reimbursement under the medical assistance
31 29 program to promote wellness and prevention, provide
31 30 care coordination, and provide chronic care
31 31 management.

31 32 b. Increasing reimbursement to Medicare levels for

31 33 certain wellness and prevention services, chronic care
31 34 management, and immunizations.

31 35 c. Providing reimbursement for primary care
31 36 services by addressing the disparities between
31 37 reimbursement for specialty services and primary care
31 38 services.

31 39 d. Increased funding for efforts to transform
31 40 medical practices into certified medical homes,
31 41 including emphasizing the implementation of the use of
31 42 electronic health records.

31 43 e. Targeted reimbursement to providers linked to
31 44 health care quality improvement measures established
31 45 by the department.

31 46 f. Reimbursement for specified ancillary support
31 47 services such as transportation for medical
31 48 appointments and other such services.

31 49 g. Providing reimbursement for medication
31 50 reconciliation and medication therapy management
32 1 service, where appropriate.

32 2 9. The department shall coordinate the
32 3 requirements and activities of the medical home system
32 4 with the requirements and activities of the dental
32 5 home for children as described in section 249J.14,
32 6 subsection 7, and shall recommend financial incentives
32 7 for dentists and nondental providers to promote oral
32 8 health care coordination through preventive dental
32 9 intervention, early identification of oral disease
32 10 risk, health care coordination and data tracking,
32 11 treatment, chronic care management, education and
32 12 training, parental guidance, and oral health
32 13 promotions for children.

32 14 10. The department shall integrate the
32 15 recommendations and policies developed by the
32 16 prevention and chronic care management advisory
32 17 council into the medical home system.

32 18 11. Implementation phases.
32 19 a. Initial implementation shall require
32 20 participation in the medical home system of children
32 21 who are recipients of full benefits under the medical
32 22 assistance program. The department shall work with
32 23 the department of human services and shall recommend
32 24 to the general assembly a reimbursement methodology to
32 25 compensate providers participating under the medical
32 26 assistance program for participation in the medical
32 27 home system.

32 28 b. The department shall work with the department
32 29 of human services to expand the medical home system to
32 30 adults who are recipients of full benefits under the
32 31 medical assistance program and the expansion
32 32 population under the IowaCare program. The department
32 33 shall work with the centers for Medicare and Medicaid
32 34 services of the United States department of health and
32 35 human services to allow Medicare recipients to utilize
32 36 the medical home system.

32 37 c. The department shall work with the department
32 38 of administrative services to allow state employees to
32 39 utilize the medical home system.

32 40 d. The department shall work with insurers and
32 41 self-insured companies, if requested, to make the
32 42 medical home system available to individuals with
32 43 private health care coverage.

32 44 12. The department shall provide oversight for all
32 45 certified medical homes. The department shall review
32 46 the progress of the medical home system and recommend
32 47 improvements to the system, as necessary.

32 48 13. The department shall annually evaluate the
32 49 medical home system and make recommendations to the
32 50 governor and the general assembly regarding
33 1 improvements to and continuation of the system.

33 2 14. Recommendations and other activities resulting
33 3 from the duties authorized for the department under
33 4 this section shall require approval by the board prior
33 5 to any subsequent action or implementation.

33 6 Sec. 47. Section 136.3, Code 2007, is amended by
33 7 adding the following new subsection:

33 8 NEW SUBSECTION. 12. Perform those duties
33 9 authorized pursuant to section 135.159.

33 10 Sec. 48. Section 249J.14, subsection 7, Code 2007,
33 11 is amended to read as follows:

33 12 7. DENTAL HOME FOR CHILDREN. By ~~July 1, 2008~~
33 13 December 31, 2010, every recipient of medical

33 14 assistance who is a child twelve years of age or
33 15 younger shall have a designated dental home and shall
33 16 be provided with the dental screenings, and preventive
33 17 ~~care identified in the oral health standards services,~~
33 18 ~~diagnostic services, treatment services, and emergency~~
33 19 ~~services as defined under the early and periodic~~

33 20 screening, diagnostic, and treatment program.
33 21 Sec. 49. MEDICAL HOME SYSTEM == APPROPRIATION.
33 22 There is appropriated from the general fund of the
33 23 state to the department of public health for the
33 24 fiscal year beginning July 1, 2008, and ending June
33 25 30, 2009, the following amount, or so much thereof as
33 26 is necessary, for the purpose designated:

33 27 For activities associated with the medical home
33 28 system requirements of this division and for not more
33 29 than the following full-time equivalent positions:
33 30 \$ 165,600
33 31 FTEs 4.00

33 32 DIVISION IX
33 33 PREVENTION AND CHRONIC CARE MANAGEMENT

33 34 DIVISION XXIII
33 35 PREVENTION AND CHRONIC CARE MANAGEMENT
33 36 Sec. 50. NEW SECTION. 135.160 DEFINITIONS.

33 37 For the purpose of this division, unless the
33 38 context otherwise requires:
33 39 1. "Board" means the state board of health created
33 40 pursuant to section 136.1.

33 41 2. "Chronic care" means health care services
33 42 provided by a health care professional for an
33 43 established clinical condition that is expected to
33 44 last a year or more and that requires ongoing clinical
33 45 management attempting to restore the individual to
33 46 highest function, minimize the negative effects of the
33 47 chronic condition, and prevent complications related
33 48 to the chronic condition.

33 49 3. "Chronic care information system" means
33 50 approved information technology to enhance the
34 1 development and communication of information to be
34 2 used in providing chronic care, including clinical,
34 3 social, and economic outcomes of chronic care.

34 4 4. "Chronic care management" means a system of
34 5 coordinated health care interventions and
34 6 communications for individuals with chronic
34 7 conditions, including significant patient self-care
34 8 efforts, systemic supports for the health care
34 9 professional and patient relationship, and a chronic
34 10 care plan emphasizing prevention of complications
34 11 utilizing evidence-based practice guidelines, patient
34 12 empowerment strategies, and evaluation of clinical,
34 13 humanistic, and economic outcomes on an ongoing basis
34 14 with the goal of improving overall health.

34 15 5. "Chronic care plan" means a plan of care
34 16 between an individual and the individual's principal
34 17 health care professional that emphasizes prevention of
34 18 complications through patient empowerment including
34 19 but not limited to providing incentives to engage the
34 20 patient in the patient's own care and in clinical,
34 21 social, or other interventions designed to minimize
34 22 the negative effects of the chronic condition.

34 23 6. "Chronic care resources" means health care
34 24 professionals, advocacy groups, health departments,
34 25 schools of public health and medicine, health plans,
34 26 and others with expertise in public health, health
34 27 care delivery, health care financing, and health care
34 28 research.

34 29 7. "Chronic condition" means an established
34 30 clinical condition that is expected to last a year or
34 31 more and that requires ongoing clinical management.

34 32 8. "Department" means the department of public
34 33 health.

34 34 9. "Director" means the director of public health.

34 35 10. "Eligible individual" means a resident of this
34 36 state who has been diagnosed with a chronic condition
34 37 or is at an elevated risk for a chronic condition and
34 38 who is a recipient of medical assistance, is a member
34 39 of the expansion population pursuant to chapter 249J,
34 40 or is an inmate of a correctional institution in this
34 41 state.

34 42 11. "Health care professional" means health care
34 43 professional as defined in section 135.157.

34 44 12. "Health risk assessment" means screening by a

34 45 health care professional for the purpose of assessing
34 46 an individual's health, including tests or physical
34 47 examinations and a survey or other tool used to gather
34 48 information about an individual's health, medical
34 49 history, and health risk factors during a health
34 50 screening.

35 1 Sec. 51. NEW SECTION. 135.161 PREVENTION AND
35 2 CHRONIC CARE MANAGEMENT INITIATIVE == ADVISORY
35 3 COUNCIL.

35 4 1. The director, in collaboration with the
35 5 prevention and chronic care management advisory
35 6 council, shall develop a state initiative for
35 7 prevention and chronic care management. The state
35 8 initiative consists of the state's plan for developing
35 9 a chronic care organizational structure for prevention
35 10 and chronic care management, including coordinating
35 11 the efforts of health care professionals and chronic
35 12 care resources to promote the health of residents and
35 13 the prevention and management of chronic conditions,
35 14 developing and implementing arrangements for
35 15 delivering prevention services and chronic care
35 16 management, developing significant patient self-care
35 17 efforts, providing systemic support for the health
35 18 care professional-patient relationship and options for
35 19 channeling chronic care resources and support to
35 20 health care professionals, providing for community
35 21 development and outreach and education efforts, and
35 22 coordinating information technology initiatives with
35 23 the chronic care information system.

35 24 2. The director may accept grants and donations
35 25 and shall apply for any federal, state, or private
35 26 grants available to fund the initiative. Any grants
35 27 or donations received shall be placed in a separate
35 28 fund in the state treasury and used exclusively for
35 29 the initiative or as federal law directs.

35 30 3. a. The director shall establish and convene an
35 31 advisory council to provide technical assistance to
35 32 the director in developing a state initiative that
35 33 integrates evidence-based prevention and chronic care
35 34 management strategies into the public and private
35 35 health care systems, including the medical home
35 36 system. Public members of the advisory council shall
35 37 receive their actual and necessary expenses incurred
35 38 in the performance of their duties and may be eligible
35 39 to receive compensation as provided in section 7E.6.

35 40 b. The advisory council shall elicit input from a
35 41 variety of health care professionals, health care
35 42 professional organizations, community and nonprofit
35 43 groups, insurers, consumers, businesses, school
35 44 districts, and state and local governments in
35 45 developing the advisory council's recommendations.

35 46 c. The advisory council shall submit initial
35 47 recommendations to the director for the state
35 48 initiative for prevention and chronic care management
35 49 no later than July 1, 2009. The recommendations shall
35 50 address all of the following:

36 1 (1) The recommended organizational structure for
36 2 integrating prevention and chronic care management
36 3 into the private and public health care systems. The
36 4 organizational structure recommended shall align with
36 5 the organizational structure established for the
36 6 medical home system developed pursuant to division
36 7 XXII. The advisory council shall also review existing
36 8 prevention and chronic care management strategies used
36 9 in the health insurance market and in private and
36 10 public programs and recommend ways to expand the use
36 11 of such strategies throughout the health insurance
36 12 market and in the private and public health care
36 13 systems.

36 14 (2) A process for identifying leading health care
36 15 professionals and existing prevention and chronic care
36 16 management programs in the state, and coordinating
36 17 care among these health care professionals and
36 18 programs.

36 19 (3) A prioritization of the chronic conditions for
36 20 which prevention and chronic care management services
36 21 should be provided, taking into consideration the
36 22 prevalence of specific chronic conditions and the
36 23 factors that may lead to the development of chronic
36 24 conditions; the fiscal impact to state health care
36 25 programs of providing care for the chronic conditions

36 26 of eligible individuals; the availability of workable,
36 27 evidence-based approaches to chronic care for the
36 28 chronic condition; and public input into the selection
36 29 process. The advisory council shall initially develop
36 30 consensus guidelines to address the two chronic
36 31 conditions identified as having the highest priority
36 32 and shall also specify a timeline for inclusion of
36 33 additional specific chronic conditions in the
36 34 initiative.

36 35 (4) A method to involve health care professionals
36 36 in identifying eligible patients for prevention and
36 37 chronic care management services, which includes but
36 38 is not limited to the use of a health risk assessment.

36 39 (5) The methods for increasing communication
36 40 between health care professionals and patients,
36 41 including patient education, patient self-management,
36 42 and patient follow-up plans.

36 43 (6) The educational, wellness, and clinical
36 44 management protocols and tools to be used by health
36 45 care professionals, including management guideline
36 46 materials for health care delivery.

36 47 (7) The use and development of process and outcome
36 48 measures and benchmarks, aligned to the greatest
36 49 extent possible with existing measures and benchmarks
36 50 such as the best in class estimates utilized in the
37 1 national healthcare quality report of the agency for
37 2 health care research and quality of the United States
37 3 department of health and human services, to provide
37 4 performance feedback for health care professionals and
37 5 information on the quality of health care, including
37 6 patient satisfaction and health status outcomes.

37 7 (8) Payment methodologies to align reimbursements
37 8 and create financial incentives and rewards for health
37 9 care professionals to utilize prevention services,
37 10 establish management systems for chronic conditions,
37 11 improve health outcomes, and improve the quality of
37 12 health care, including case management fees, payment
37 13 for technical support and data entry associated with
37 14 patient registries, and the cost of staff coordination
37 15 within a medical practice.

37 16 (9) Methods to involve public and private groups,
37 17 health care professionals, insurers, third-party
37 18 administrators, associations, community and consumer
37 19 groups, and other entities to facilitate and sustain
37 20 the initiative.

37 21 (10) Alignment of any chronic care information
37 22 system or other information technology needs with
37 23 other health care information technology initiatives.

37 24 (11) Involvement of appropriate health resources
37 25 and public health and outcomes researchers to develop
37 26 and implement a sound basis for collecting data and
37 27 evaluating the clinical, social, and economic impact
37 28 of the initiative, including a determination of the
37 29 impact on expenditures and prevalence and control of
37 30 chronic conditions.

37 31 (12) Elements of a marketing campaign that
37 32 provides for public outreach and consumer education in
37 33 promoting prevention and chronic care management
37 34 strategies among health care professionals, health
37 35 insurers, and the public.

37 36 (13) A method to periodically determine the
37 37 percentage of health care professionals who are
37 38 participating, the success of the
37 39 empowerment-of-patients approach, and any results of
37 40 health outcomes of the patients participating.

37 41 (14) A means of collaborating with the health
37 42 professional licensing boards pursuant to chapter 147
37 43 to review prevention and chronic care management
37 44 education provided to licensees, as appropriate, and
37 45 recommendations regarding education resources and
37 46 curricula for integration into existing and new
37 47 education and training programs.

37 48 4. Following submission of initial recommendations
37 49 to the director for the state initiative for
37 50 prevention and chronic care management by the advisory
38 1 council, the director shall submit the state
38 2 initiative to the board for approval. Subject to
38 3 approval of the state initiative by the board, the
38 4 department shall initially implement the state
38 5 initiative among the population of eligible
38 6 individuals. Following initial implementation, the

38 7 director shall work with the department of human
38 8 services, insurers, health care professional
38 9 organizations, and consumers in implementing the
38 10 initiative beyond the population of eligible
38 11 individuals as an integral part of the health care
38 12 delivery system in the state. The advisory council
38 13 shall continue to review and make recommendations to
38 14 the director regarding improvements to the initiative.
38 15 Any recommendations are subject to approval by the
38 16 board.

38 17 Sec. 52. NEW SECTION. 135.162 CLINICIANS
38 18 ADVISORY PANEL.

38 19 1. The director shall convene a clinicians
38 20 advisory panel to advise and recommend to the
38 21 department clinically appropriate, evidence-based best
38 22 practices regarding the implementation of the medical
38 23 home as defined in section 135.157 and the prevention
38 24 and chronic care management initiative pursuant to
38 25 section 135.161. The director shall act as
38 26 chairperson of the advisory panel.

38 27 2. The clinicians advisory panel shall consist of
38 28 nine members representing licensed medical health care
38 29 providers selected by their respective professional
38 30 organizations. Terms of members shall begin and end
38 31 as provided in section 69.19. Any vacancy shall be
38 32 filled in the same manner as regular appointments are
38 33 made for the unexpired portion of the regular term.
38 34 Members shall serve terms of three years. A member is
38 35 eligible for reappointment for three successive terms.

38 36 3. The clinicians advisory panel shall meet on a
38 37 quarterly basis to receive updates from the director
38 38 regarding strategic planning and implementation
38 39 progress on the medical home and the prevention and
38 40 chronic care management initiative and shall provide
38 41 clinical consultation to the department regarding the
38 42 medical home and the initiative.

38 43 Sec. 53. Section 136.3, Code 2007, is amended by
38 44 adding the following new subsection:

38 45 NEW SUBSECTION. 13. Perform those duties
38 46 authorized pursuant to section 135.161.

38 47 Sec. 54. PREVENTION AND CHRONIC CARE MANAGEMENT ==
38 48 APPROPRIATION. There is appropriated from the general
38 49 fund of the state to the department of public health
38 50 for the fiscal year beginning July 1, 2008, and ending
39 1 June 30, 2009, the following amount, or so much
39 2 thereof as is necessary, for the purpose designated:

39 3 For activities associated with the prevention and
39 4 chronic care management requirements of this division:
39 5 \$ 190,500

39 6 DIVISION X

39 7 FAMILY OPPORTUNITY ACT

39 8 Sec. 55. 2007 Iowa Acts, chapter 218, section 126,
39 9 subsection 1, is amended to read as follows:

39 10 1. The provision in this division of this Act
39 11 relating to eligibility for certain persons with
39 12 disabilities under the medical assistance program
39 13 shall ~~only be implemented if the department of human~~
39 14 ~~services determines that funding is available in~~
39 15 ~~appropriations made in this Act, in combination with~~
39 16 ~~federal allocations to the state, for the state~~
39 17 ~~children's health insurance program, in excess of the~~
39 18 ~~amount needed to cover the current and projected~~
39 19 ~~enrollment under the state children's health insurance~~
39 20 ~~program beginning January 1, 2009. If such a~~
39 21 ~~determination is made, the department of human~~
39 22 ~~services shall transfer funding from the~~
39 23 ~~appropriations made in this Act for the state~~
39 24 ~~children's health insurance program, not otherwise~~
39 25 ~~required for that program, to the appropriations made~~
39 26 ~~in this Act for medical assistance, as necessary, to~~
39 27 ~~implement such provision of this division of this Act.~~

39 28 DIVISION XI

39 29 MEDICAL ASSISTANCE QUALITY IMPROVEMENT

39 30 Sec. 56. NEW SECTION. 249A.36 MEDICAL ASSISTANCE
39 31 QUALITY IMPROVEMENT COUNCIL.

39 32 1. A medical assistance quality improvement
39 33 council is established. The council shall evaluate
39 34 the clinical outcomes and satisfaction of consumers
39 35 and providers with the medical assistance program.
39 36 The council shall coordinate efforts with the cost and
39 37 quality performance evaluation completed pursuant to

39 38 section 249J.16. The council shall also coordinate
39 39 its efforts with the efforts of the department of
39 40 public health regarding health care consumer
39 41 information under section 135.163.

39 42 2. a. The council shall consist of seven voting
39 43 members appointed by the majority leader of the
39 44 senate, the minority leader of the senate, the speaker
39 45 of the house, and the minority leader of the house of
39 46 representatives. At least one member of the council
39 47 shall be a consumer and at least one member shall be a
39 48 medical assistance program provider. An individual
39 49 who is employed by a private or nonprofit organization
39 50 that receives one million dollars or more in
40 1 compensation or reimbursement from the department,
40 2 annually, is not eligible for appointment to the
40 3 council. The members shall serve terms of two years
40 4 beginning and ending as provided in section 69.19, and
40 5 appointments shall comply with sections 69.16 and
40 6 69.16A. Members shall receive reimbursement for
40 7 actual expenses incurred while serving in their
40 8 official capacity and may also be eligible to receive
40 9 compensation as provided in section 7E.6. Vacancies
40 10 shall be filled by the original appointing authority
40 11 and in the manner of the original appointment. A
40 12 person appointed to fill a vacancy shall serve only
40 13 for the unexpired portion of the term.

40 14 b. The members shall select a chairperson,
40 15 annually, from among the membership. The council
40 16 shall meet at least quarterly and at the call of the
40 17 chairperson. A majority of the members of the council
40 18 constitutes a quorum. Any action taken by the council
40 19 must be adopted by the affirmative vote of a majority
40 20 of its voting membership.

40 21 c. The department shall provide administrative
40 22 support and necessary supplies and equipment for the
40 23 council.

40 24 3. The council shall consult with and advise the
40 25 Iowa Medicaid enterprise in establishing a quality
40 26 assessment and improvement process.

40 27 a. The process shall be consistent with the health
40 28 plan employer data and information set developed by
40 29 the national committee for quality assurance and with
40 30 the consumer assessment of health care providers and
40 31 systems developed by the agency for health care
40 32 research and quality of the United States department
40 33 of health and human services. The council shall also
40 34 coordinate efforts with the Iowa healthcare
40 35 collaborative and the state's Medicare quality
40 36 improvement organization to create consistent quality
40 37 measures.

40 38 b. The process may utilize as a basis the medical
40 39 assistance and state children's health insurance
40 40 quality improvement efforts of the centers for
40 41 Medicare and Medicaid services of the United States
40 42 department of health and human services.

40 43 c. The process shall include assessment and
40 44 evaluation of both managed care and fee-for-service
40 45 programs, and shall be applicable to services provided
40 46 to adults and children.

40 47 d. The initial process shall be developed and
40 48 implemented by December 31, 2008, with the initial
40 49 report of results to be made available to the public
40 50 by June 30, 2009. Following the initial report, the
41 1 council shall submit a report of results to the
41 2 governor and the general assembly, annually, in
41 3 January.

41 4 DIVISION XII
41 5 HEALTH CARE CONSUMER INFORMATION
41 6 DIVISION XXIV
41 7 HEALTH CARE CONSUMER INFORMATION
41 8 Sec. 57. NEW SECTION. 135.163 HEALTH CARE
41 9 CONSUMER INFORMATION.

41 10 The department shall do all of the following to
41 11 improve consumer education about health cost and
41 12 quality:

41 13 1. Provide for coordination of efforts to promote
41 14 public reporting of hospital and physician quality
41 15 measures, including efforts of the Iowa healthcare
41 16 collaborative, the state's Medicare quality
41 17 improvement organization, the Iowa Medicaid
41 18 enterprise, and the medical assistance quality

41 19 improvement council established pursuant to section
41 20 249A.36.

41 21 2. Provide for the coordination of efforts to
41 22 promote public reporting of health care costs,
41 23 including efforts of the Iowa hospital association,
41 24 Iowa medical society, and the Iowa health buyers'
41 25 alliance.

41 26 3. Create a public awareness campaign to educate
41 27 consumers about enhanced health through lifestyle
41 28 choices.

41 29 4. Promote adoption of health information
41 30 technology through provider incentives.

41 31 5. Evaluate the efficacy of a standard medication
41 32 therapy management program.

41 33 DIVISION XIII

41 34 HEALTH AND LONG-TERM CARE ACCESS

41 35 Sec. 58. Section 135.63, subsection 2, paragraph
41 36 1, Code 2007, is amended to read as follows:

41 37 1. The replacement or modernization of any
41 38 institutional health facility if the replacement or
41 39 modernization does not add new health services or
41 40 additional bed capacity for existing health services,
41 41 notwithstanding any provision in this division to the
41 42 contrary. In addition, with reference to a hospital,
41 43 "replacement" means establishing a new hospital that
41 44 demonstrates compliance with all of the following
41 45 criteria through evidence submitted to the department:

41 46 (1) Serves at least seventy-five percent of the
41 47 same service area that was served by the prior
41 48 hospital to be closed and replaced by the new
41 49 hospital.

41 50 (2) Provides at least seventy-five percent of the
42 1 same services that were provided by the prior hospital
42 2 to be closed and replaced by the new hospital.

42 3 (3) Is staffed by at least seventy-five percent of
42 4 the same staff, including medical staff, contracted
42 5 staff, and employees, as constituted the staff of the
42 6 prior hospital to be closed and replaced by the new
42 7 hospital.

42 8 Sec. 59. NEW SECTION. 135.164 HEALTH AND
42 9 LONG-TERM CARE ACCESS.

42 10 The department shall coordinate public and private
42 11 efforts to develop and maintain an appropriate health
42 12 care delivery infrastructure and a stable,
42 13 well-qualified, diverse, and sustainable health care
42 14 workforce in this state. The health care delivery
42 15 infrastructure and the health care workforce shall
42 16 address the broad spectrum of health care needs of
42 17 Iowans throughout their lifespan including long-term
42 18 care needs. The department shall, at a minimum, do
42 19 all of the following:

42 20 1. Develop a strategic plan for health care
42 21 delivery infrastructure and health care workforce
42 22 resources in this state.

42 23 2. Provide for the continuous collection of data
42 24 to provide a basis for health care strategic planning
42 25 and health care policymaking.

42 26 3. Make recommendations regarding the health care
42 27 delivery infrastructure and the health care workforce
42 28 that assist in monitoring current needs, predicting
42 29 future trends, and informing policymaking.

42 30 Sec. 60. NEW SECTION. 135.165 STRATEGIC PLAN.

42 31 1. The strategic plan for health care delivery
42 32 infrastructure and health care workforce resources
42 33 shall describe the existing health care system,
42 34 describe and provide a rationale for the desired
42 35 health care system, provide an action plan for
42 36 implementation, and provide methods to evaluate the
42 37 system. The plan shall incorporate expenditure
42 38 control methods and integrate criteria for
42 39 evidence-based health care. The department shall do
42 40 all of the following in developing the strategic plan
42 41 for health care delivery infrastructure and health
42 42 care workforce resources:

42 43 a. Conduct strategic health planning activities
42 44 related to preparation of the strategic plan.

42 45 b. Develop a computerized system for accessing,
42 46 analyzing, and disseminating data relevant to
42 47 strategic health planning. The department may enter
42 48 into data sharing agreements and contractual
42 49 arrangements necessary to obtain or disseminate

42 50 relevant data.

43 1 c. Conduct research and analysis or arrange for
43 2 research and analysis projects to be conducted by
43 3 public or private organizations to further the
43 4 development of the strategic plan.

43 5 d. Establish a technical advisory committee to
43 6 assist in the development of the strategic plan. The
43 7 members of the committee may include but are not
43 8 limited to health economists, representatives of the
43 9 university of Iowa college of public health, health
43 10 planners, representatives of health care purchasers,
43 11 representatives of state and local agencies that
43 12 regulate entities involved in health care,
43 13 representatives of health care providers and health
43 14 care facilities, and consumers.

43 15 2. The strategic plan shall include statewide
43 16 health planning policies and goals related to the
43 17 availability of health care facilities and services,
43 18 the quality of care, and the cost of care. The
43 19 policies and goals shall be based on the following
43 20 principles:

43 21 a. That a strategic health planning process,
43 22 responsive to changing health and social needs and
43 23 conditions, is essential to the health, safety, and
43 24 welfare of Iowans. The process shall be reviewed and
43 25 updated as necessary to ensure that the strategic plan
43 26 addresses all of the following:

43 27 (1) Promoting and maintaining the health of all
43 28 Iowans.

43 29 (2) Providing accessible health care services
43 30 through the maintenance of an adequate supply of
43 31 health facilities and an adequate workforce.

43 32 (3) Controlling excessive increases in costs.

43 33 (4) Applying specific quality criteria and
43 34 population health indicators.

43 35 (5) Recognizing prevention and wellness as
43 36 priorities in health care programs to improve quality
43 37 and reduce costs.

43 38 (6) Addressing periodic priority issues including
43 39 disaster planning, public health threats, and public
43 40 safety dilemmas.

43 41 (7) Coordinating health care delivery and resource
43 42 development efforts among state agencies including
43 43 those tasked with facility, services, and professional
43 44 provider licensure; state and federal reimbursement;
43 45 health service utilization data systems; and others.

43 46 (8) Recognizing long-term care as an integral
43 47 component of the health care delivery infrastructure
43 48 and as an essential service provided by the health
43 49 care workforce.

43 50 b. That both consumers and providers throughout
44 1 the state must be involved in the health planning
44 2 process, outcomes of which shall be clearly
44 3 articulated and available for public review and use.

44 4 c. That the supply of a health care service has a
44 5 substantial impact on utilization of the service,
44 6 independent of the effectiveness, medical necessity,
44 7 or appropriateness of the particular health care
44 8 service for a particular individual.

44 9 d. That given that health care resources are not
44 10 unlimited, the impact of any new health care service
44 11 or facility on overall health expenditures in this
44 12 state must be considered.

44 13 e. That excess capacity of health care services
44 14 and facilities places an increased economic burden on
44 15 the public.

44 16 f. That the likelihood that a requested new health
44 17 care facility, service, or equipment will improve
44 18 health care quality and outcomes must be considered.

44 19 g. That development and ongoing maintenance of
44 20 current and accurate health care information and
44 21 statistics related to cost and quality of health care
44 22 and projections of the need for health care facilities
44 23 and services are necessary to developing an effective
44 24 health care planning strategy.

44 25 h. That the certificate of need program as a
44 26 component of the health care planning regulatory
44 27 process must balance considerations of access to
44 28 quality care at a reasonable cost for all Iowans,
44 29 optimal use of existing health care resources,
44 30 fostering of expenditure control, and elimination of

44 31 unnecessary duplication of health care facilities and
44 32 services, while supporting improved health care
44 33 outcomes.

44 34 i. That strategic health care planning must be
44 35 concerned with the stability of the health care
44 36 system, encompassing health care financing, quality,
44 37 and the availability of information and services for
44 38 all residents.

44 39 3. The health care delivery infrastructure and
44 40 health care workforce resources strategic plan
44 41 developed by the department shall include all of the
44 42 following:

44 43 a. A health care system assessment and objectives
44 44 component that does all of the following:

44 45 (1) Describes state and regional population
44 46 demographics, health status indicators, and trends in
44 47 health status and health care needs.

44 48 (2) Identifies key policy objectives for the state
44 49 health care system related to access to care, health
44 50 care outcomes, quality, and cost-effectiveness.

45 1 b. A health care facilities and services plan that
45 2 assesses the demand for health care facilities and
45 3 services to inform state health care planning efforts
45 4 and direct certificate of need determinations, for
45 5 those facilities and services subject to certificate
45 6 of need. The plan shall include all of the following:

45 7 (1) An inventory of each geographic region's
45 8 existing health care facilities and services.

45 9 (2) Projections of the need for each category of
45 10 health care facility and service, including those
45 11 subject to certificate of need.

45 12 (3) Policies to guide the addition of new or
45 13 expanded health care facilities and services to
45 14 promote the use of quality, evidence-based,
45 15 cost-effective health care delivery options, including
45 16 any recommendations for criteria, standards, and
45 17 methods relevant to the certificate of need review
45 18 process.

45 19 (4) An assessment of the availability of health
45 20 care providers, public health resources,
45 21 transportation infrastructure, and other
45 22 considerations necessary to support the needed health
45 23 care facilities and services in each region.

45 24 c. A health care data resources plan that
45 25 identifies data elements necessary to properly conduct
45 26 planning activities and to review certificate of need
45 27 applications, including data related to inpatient and
45 28 outpatient utilization and outcomes information, and
45 29 financial and utilization information related to
45 30 charity care, quality, and cost. The plan shall
45 31 provide all of the following:

45 32 (1) An inventory of existing data resources, both
45 33 public and private, that store and disclose
45 34 information relevant to the health care planning
45 35 process, including information necessary to conduct
45 36 certificate of need activities. The plan shall
45 37 identify any deficiencies in the inventory of existing
45 38 data resources and the data necessary to conduct
45 39 comprehensive health care planning activities. The
45 40 plan may recommend that the department be authorized
45 41 to access existing data sources and conduct
45 42 appropriate analyses of such data or that other
45 43 agencies expand their data collection activities as
45 44 statutory authority permits. The plan may identify
45 45 any computing infrastructure deficiencies that impede
45 46 the proper storage, transmission, and analysis of
45 47 health care planning data.

45 48 (2) Recommendations for increasing the
45 49 availability of data related to health care planning
45 50 to provide greater community involvement in the health
46 1 care planning process and consistency in data used for
46 2 certificate of need applications and determinations.

46 3 The plan shall also integrate the requirements for
46 4 annual reports by hospitals and health care facilities
46 5 pursuant to section 135.75, the provisions relating to
46 6 analyses and studies by the department pursuant to
46 7 section 135.76, the data compilation provisions of
46 8 section 135.78, and the provisions for contracts for
46 9 assistance with analyses, studies, and data pursuant
46 10 to section 135.83.

46 11 d. An assessment of emerging trends in health care

46 12 delivery and technology as they relate to access to
46 13 health care facilities and services, quality of care,
46 14 and costs of care. The assessment shall recommend any
46 15 changes to the scope of health care facilities and
46 16 services covered by the certificate of need program
46 17 that may be warranted by these emerging trends. In
46 18 addition, the assessment may recommend any changes to
46 19 criteria used by the department to review certificate
46 20 of need applications, as necessary.

46 21 e. A rural health care resources plan to assess
46 22 the availability of health resources in rural areas of
46 23 the state, assess the unmet needs of these
46 24 communities, and evaluate how federal and state
46 25 reimbursement policies can be modified, if necessary,
46 26 to more efficiently and effectively meet the health
46 27 care needs of rural communities. The plan shall
46 28 consider the unique health care needs of rural
46 29 communities, the adequacy of the rural health care
46 30 workforce, and transportation needs for accessing
46 31 appropriate care.

46 32 f. A health care workforce resources plan to
46 33 assure a competent, diverse, and sustainable health
46 34 care workforce in Iowa and to improve access to health
46 35 care in underserved areas and among underserved
46 36 populations. The plan shall include the establishment
46 37 of an advisory council to inform and advise the
46 38 department and policymakers regarding issues relevant
46 39 to the health care workforce in Iowa. The health care
46 40 workforce resources plan shall recognize long-term
46 41 care as an essential service provided by the health
46 42 care workforce.

46 43 4. The department shall submit the initial
46 44 statewide health care delivery infrastructure and
46 45 resources strategic plan to the governor and the
46 46 general assembly by January 1, 2010, and shall submit
46 47 an updated strategic plan to the governor and the
46 48 general assembly every two years thereafter.

46 49 Sec. 61. HEALTH CARE ACCESS == APPROPRIATION.
46 50 There is appropriated from the general fund of the
47 1 state to the department of public health for the
47 2 fiscal year beginning July 1, 2008, and ending June
47 3 30, 2009, the following amount, or so much thereof as
47 4 is necessary, for the purpose designated:

47 5	For activities associated with the health care	
47 6	access requirements of this division, and for not more	
47 7	than the following full-time equivalent positions:	
47 8 \$	172,200
47 9 FTEs	3.00

47 10 DIVISION XIV
47 11 PREVENTION AND WELLNESS
47 12 INITIATIVES

47 13 Sec. 62. Section 135.27, Code 2007, is amended by
47 14 striking the section and inserting in lieu thereof the
47 15 following:

47 16 135.27 IOWA HEALTHY COMMUNITIES INITIATIVE ==
47 17 GRANT PROGRAM.

47 18 1. PROGRAM GOALS. The department shall establish
47 19 a grant program to energize local communities to
47 20 transform the existing culture into a culture that
47 21 promotes healthy lifestyles and leads collectively,
47 22 community by community, to a healthier state. The
47 23 grant program shall expand an existing healthy
47 24 communities initiative to assist local boards of
47 25 health, in collaboration with existing community
47 26 resources, to build community capacity in addressing
47 27 the prevention of chronic disease that results from
47 28 risk factors including overweight and obesity
47 29 conditions.

47 30 2. DISTRIBUTION OF GRANTS. The department shall
47 31 distribute the grants on a competitive basis and shall
47 32 support the grantee communities in planning and
47 33 developing wellness strategies and establishing
47 34 methodologies to sustain the strategies. Grant
47 35 criteria shall be consistent with the existing
47 36 statewide initiative between the department and the
47 37 department's partners that promotes increased
47 38 opportunities for physical activity and healthy eating
47 39 for Iowans of all ages, or its successor, and the
47 40 statewide comprehensive plan developed by the existing
47 41 statewide initiative to increase physical activity,
47 42 improve nutrition, and promote healthy behaviors.

47 43 Grantees shall demonstrate an ability to maximize
47 44 local, state, and federal resources effectively and
47 45 efficiently.

47 46 3. DEPARTMENTAL SUPPORT. The department shall
47 47 provide support to grantees including
47 48 capacity-building strategies, technical assistance,
47 49 consultation, and ongoing evaluation.

47 50 4. ELIGIBILITY. Local boards of health
48 1 representing a coalition of health care providers and
48 2 community and private organizations are eligible to
48 3 submit applications.

48 4 Sec. 63. NEW SECTION. 135.27A GOVERNOR'S COUNCIL
48 5 ON PHYSICAL FITNESS AND NUTRITION.

48 6 1. A governor's council on physical fitness and
48 7 nutrition is established consisting of twelve members
48 8 appointed by the governor who have expertise in
48 9 physical activity, physical fitness, nutrition, and
48 10 promoting healthy behaviors. At least one member
48 11 shall be a representative of elementary and secondary
48 12 physical education professionals, at least one member
48 13 shall be a health care professional, at least one
48 14 member shall be a registered dietician, at least one
48 15 member shall be recommended by the department of elder
48 16 affairs, and at least one member shall be an active
48 17 nutrition or fitness professional. In addition, at
48 18 least one member shall be a member of a racial or
48 19 ethnic minority. The governor shall select a
48 20 chairperson for the council. Members shall serve
48 21 terms of three years beginning and ending as provided
48 22 in section 69.19. Appointments are subject to
48 23 sections 69.16 and 69.16A. Members are entitled to
48 24 receive reimbursement for actual expenses incurred
48 25 while engaged in the performance of official duties.
48 26 A member of the council may also be eligible to
48 27 receive compensation as provided in section 7E.6.

48 28 2. The council shall assist in developing a
48 29 strategy for implementation of the statewide
48 30 comprehensive plan developed by the existing statewide
48 31 initiative to increase physical activity, improve
48 32 physical fitness, improve nutrition, and promote
48 33 healthy behaviors. The strategy shall include
48 34 specific components relating to specific populations
48 35 and settings including early childhood, educational,
48 36 local community, worksite wellness, health care, and
48 37 older Iowans. The initial draft of the implementation
48 38 plan shall be submitted to the governor and the
48 39 general assembly by December 1, 2008.

48 40 3. The council shall assist the department in
48 41 establishing and promoting a best practices internet
48 42 site. The internet site shall provide examples of
48 43 wellness best practices for individuals, communities,
48 44 workplaces, and schools and shall include successful
48 45 examples of both evidence-based and nonscientific
48 46 programs as a resource.

48 47 4. The council shall provide oversight for the
48 48 governor's physical fitness challenge. The governor's
48 49 physical fitness challenge shall be administered by
48 50 the department and shall provide for the establishment
49 1 of partnerships with communities or school districts
49 2 to offer the physical fitness challenge curriculum to
49 3 elementary and secondary school students. The council
49 4 shall develop the curriculum, including benchmarks and
49 5 rewards, for advancing the school wellness policy
49 6 through the challenge.

49 7 Sec. 64. IOWA HEALTHY COMMUNITIES INITIATIVE ==
49 8 APPROPRIATION. There is appropriated from the general
49 9 fund of the state to the department of public health
49 10 for the fiscal year beginning July 1, 2008, and ending
49 11 June 30, 2009, the following amount, or so much
49 12 thereof as is necessary, for the purpose designated:

49 13 For Iowa healthy communities initiative grants
49 14 distributed beginning January 1, 2009, and for not
49 15 more than the following full-time equivalent
49 16 positions:

49 17	\$	900,000
49 18	FTEs	3.00

49 19 Sec. 65. GOVERNOR'S COUNCIL ON PHYSICAL FITNESS
49 20 AND NUTRITION == APPROPRIATION. There is appropriated
49 21 from the general fund of the state to the department
49 22 of public health for the fiscal period beginning July
49 23 1, 2008, and ending June 30, 2009, the following

49 24 amount, or so much thereof as is necessary, for the
49 25 purpose designated:
49 26 For the governor's council on physical fitness:
49 27 \$ 112,100

49 28 Sec. 66. SMALL BUSINESS QUALIFIED WELLNESS PROGRAM
49 29 TAX CREDIT == PLAN. The department of public health,
49 30 in consultation with the insurance division of the
49 31 department of commerce and the department of revenue,
49 32 shall develop a plan to provide a tax credit to small
49 33 businesses that provide qualified wellness programs to
49 34 improve the health of their employees. The plan shall
49 35 include specification of what constitutes a small
49 36 business for the purposes of the qualified wellness
49 37 program, the minimum standards for use by a small
49 38 business in establishing a qualified wellness program,
49 39 the criteria and a process for certification of a
49 40 small business qualified wellness program, and the
49 41 process for claiming a small business qualified
49 42 wellness program tax credit. The department of public
49 43 health shall submit the plan including any
49 44 recommendations for changes in law to implement a
49 45 small business qualified wellness program tax credit
49 46 to the governor and the general assembly by December
49 47 15, 2008.

49 48 DIVISION XV
49 49 HEALTH CARE TRANSPARENCY
49 50 DIVISION XXVI

50 1 HEALTH CARE TRANSPARENCY
50 2 Sec. 67. NEW SECTION. 135.166 HEALTH CARE
50 3 TRANSPARENCY == REPORTING REQUIREMENTS.

50 4 1. A hospital licensed pursuant to chapter 135B a
50 5 physician licensed pursuant to chapter 148, 150, or
50 6 150A, and a chiropractor licensed pursuant to chapter
50 7 151 shall report quality indicators, annually, to the
50 8 Iowa healthcare collaborative as defined in section
50 9 135.40. The indicators shall be developed by the Iowa
50 10 healthcare collaborative in accordance with
50 11 evidence-based practice parameters and appropriate
50 12 sample size for statistical validation and shall be
50 13 modeled on national indicators as specified in this
50 14 section.

50 15 2. A manufacturer or supplier of durable medical
50 16 equipment or medical supplies doing business in the
50 17 state shall submit a price list to the department of
50 18 human services, annually, for use in comparing prices
50 19 for such equipment and supplies with rates paid under
50 20 the medical assistance program. The price lists
50 21 submitted shall be made available to the public.

50 22 3. Each hospital in the state that is recognized
50 23 by the Internal Revenue Code as a nonprofit
50 24 organization or entity shall submit, to the department
50 25 of public health and to the legislative services
50 26 agency, annually, a copy of the hospital's internal
50 27 revenue service form 990, including but not limited to
50 28 schedule J or any successor schedule that provides
50 29 compensation information for certain officers,
50 30 directors, trustees, and key employees, and highest
50 31 compensated employees within ninety days following the
50 32 due date for filing the hospital's return for the
50 33 taxable year.

50 34 4. a. The Iowa healthcare collaborative shall
50 35 publicly report indicators and measures including but
50 36 not limited to quality, patient safety, pediatric
50 37 care, patient safety indicators and measures as
50 38 developed by such nationally recognized entities as
50 39 the agency for healthcare research and quality of the
50 40 United States department of health and human services
50 41 and the centers for Medicare and Medicaid services of
50 42 the United States department of health and human
50 43 services and similar national entities.

50 44 b. The Iowa healthcare collaborative shall also
50 45 report health care acquired infection measures and
50 46 indicators after validity measures have been developed
50 47 in conjunction with the state epidemiologist and after
50 48 legal protections for health care providers subject to
50 49 reporting such data have been established.

50 50 Sec. 68. Section 136.3, Code 2007, is amended by
51 1 adding the following new subsection:

51 2 NEW SUBSECTION. 14. To the greatest extent
51 3 possible integrate the efforts of the governing
51 4 entities of the Iowa health information technology

51 5 system pursuant to division XXI, the medical home
51 6 pursuant to division XXII, the prevention and chronic
51 7 care management initiative pursuant to division XXIII,
51 8 consumer information provisions pursuant to division
51 9 XXIV, and health and long-term care access pursuant to
51 10 division XXV.

DIVISION XVI

DIRECT CARE WORKFORCE

51 13 Sec. 69. DIRECT CARE WORKER ADVISORY COUNCIL ==
51 14 DUTIES == REPORT.

51 15 1. As used in this section, unless the context
51 16 otherwise requires:

51 17 a. "Department" means the department of public
51 18 health.

51 19 b. "Direct care" means environmental or chore
51 20 services, health monitoring and maintenance,
51 21 assistance with instrumental activities of daily
51 22 living, assistance with personal care activities of
51 23 daily living, personal care support, or specialty
51 24 skill services.

51 25 c. "Direct care worker" means an individual who
51 26 directly provides or assists a consumer in the care of
51 27 the consumer by providing direct care in a variety of
51 28 settings which may or may not require supervision of
51 29 the direct care worker, depending on the setting and
51 30 the skills that the direct care workers possess, based
51 31 on education or certification.

51 32 d. "Director" means the director of public health.

51 33 2. A direct care worker advisory council shall be
51 34 appointed by the director and shall include
51 35 representatives of direct care workers, consumers of
51 36 direct care services, educators of direct care
51 37 workers, other health professionals, employers of
51 38 direct care workers, and appropriate state agencies.

51 39 3. Membership, terms of office, quorum, and
51 40 expenses shall be determined by the director in
51 41 accordance with the applicable provisions of section
51 42 135.11.

51 43 4. The direct care worker advisory council shall
51 44 advise the director regarding regulation and
51 45 certification of direct care workers, based on the
51 46 work of the direct care workers task force established
51 47 pursuant to 2005 Iowa Acts, chapter 88, and shall
51 48 develop recommendations regarding but not limited to
51 49 all of the following:

51 50 a. Direct care worker classifications based on
52 1 functions and services provided by direct care
52 2 workers.

52 3 b. Functions for each direct care worker
52 4 classification.

52 5 c. An education and training orientation to be
52 6 provided by employers.

52 7 d. Education and training requirements for each
52 8 direct care worker classification.

52 9 e. The standard curriculum required for each
52 10 direct care worker classification.

52 11 f. Education and training equivalency standards
52 12 for each direct care worker classification.

52 13 g. Guidelines that allow individuals who are
52 14 members of the direct care workforce prior to the date
52 15 of required certification to be incorporated into the
52 16 new regulatory system.

52 17 h. Continuing education requirements for each
52 18 direct care worker classification.

52 19 i. Standards for direct care worker educators and
52 20 trainers.

52 21 j. Certification requirements for each direct care
52 22 worker classification.

52 23 k. Protections for the title "certified direct
52 24 care worker".

52 25 l. Standardized requirements for supervision of
52 26 each direct care worker classification, as applicable,
52 27 and the roles and responsibilities of supervisory
52 28 positions.

52 29 m. Responsibility for maintenance of credentialing
52 30 and continuing education and training.

52 31 n. Provision of information to income maintenance
52 32 workers and case managers under the purview of the
52 33 department of human services about the education and
52 34 training requirements for direct care workers to
52 35 provide the care and services to meet consumer needs.

52 36 5. The direct care worker advisory council shall
52 37 report its recommendations to the director by November
52 38 30, 2008, including recommendations for any changes in
52 39 law or rules necessary.

52 40 6. Implementation of certification of direct care
52 41 workers shall begin July 1, 2009.

52 42 Sec. 70. DIRECT CARE WORKER COMPENSATION ADVISORY
52 43 COMMITTEE == REVIEWS.

52 44 1. a. The general assembly recognizes that direct
52 45 care workers play a vital role and make a valuable
52 46 contribution in providing care to Iowans with a
52 47 variety of needs in both institutional and home and
52 48 community-based settings. Recruiting and retaining
52 49 qualified, highly competent direct care workers is a
52 50 challenge across all employment settings. High rates
53 1 of employee vacancies and staff turnover threaten the
53 2 ability of providers to achieve the core mission of
53 3 providing safe and high quality support to Iowans.

53 4 b. It is the intent of the general assembly to
53 5 address the long-term care workforce shortage and
53 6 turnover rates in order to improve the quality of
53 7 health care delivered in the long-term care continuum
53 8 by reviewing wages and other compensation paid to
53 9 direct care workers in the state.

53 10 c. It is the intent of the general assembly that
53 11 the initial review of and recommendations for
53 12 improving wages and other compensation paid to direct
53 13 care workers focus on nonlicensed direct care workers
53 14 in the nursing facility setting. However, following
53 15 the initial review of wages and other compensation
53 16 paid to direct care workers in the nursing facility
53 17 setting, the department of human services shall
53 18 convene subsequent advisory committees with
53 19 appropriate representatives of public and private
53 20 organizations and consumers to review the wages and
53 21 other compensation paid to and turnover rates of the
53 22 entire spectrum of direct care workers in the various
53 23 settings in which they are employed as a means of
53 24 demonstrating the general assembly's commitment to
53 25 ensuring a stable and quality direct care workforce in
53 26 this state.

53 27 2. The department of human services shall convene
53 28 an initial direct care worker compensation advisory
53 29 committee to develop recommendations for consideration
53 30 by the general assembly during the 2009 legislative
53 31 session regarding wages and other compensation paid to
53 32 direct care workers in nursing facilities. The
53 33 committee shall consist of the following members,
53 34 selected by their respective organizations:

53 35 a. The director of human services, or the
53 36 director's designee.

53 37 b. The director of public health, or the
53 38 director's designee.

53 39 c. The director of the department of elder
53 40 affairs, or the director's designee.

53 41 d. The director of the department of inspections
53 42 and appeals, or the director's designee.

53 43 e. A representative of the Iowa caregivers
53 44 association.

53 45 f. A representative of the Iowa health care
53 46 association.

53 47 g. A representative of the Iowa association of
53 48 homes and services for the aging.

53 49 h. A representative of the AARP Iowa chapter.

53 50 3. The advisory committee shall also include two
54 1 members of the senate and two members of the house of
54 2 representatives, with not more than one member from
54 3 each chamber being from the same political party. The
54 4 legislative members shall serve in an ex officio,
54 5 nonvoting capacity. The two senators shall be
54 6 appointed respectively by the majority leader of the
54 7 senate and the minority leader of the senate, and the
54 8 two representatives shall be appointed respectively by
54 9 the speaker of the house of representatives and the
54 10 minority leader of the house of representatives.

54 11 4. Public members of the committee shall receive
54 12 actual expenses incurred while serving in their
54 13 official capacity and may also be eligible to receive
54 14 compensation as provided in section 7E.6. Legislative
54 15 members of the committee are eligible for per diem and
54 16 reimbursement of actual expenses as provided in

54 17 section 2.10.
54 18 5. The department of human services shall provide
54 19 administrative support to the committee and the
54 20 director of human services or the director's designee
54 21 shall serve as chairperson of the committee.
54 22 6. The department shall convene the committee no
54 23 later than July 1, 2008. Prior to the initial
54 24 meeting, the department of human services shall
54 25 provide all members of the committee with a detailed
54 26 analysis of trends in wages and other compensation
54 27 paid to direct care workers.
54 28 7. The committee shall consider options related
54 29 but not limited to all of the following:
54 30 a. The shortening of the time delay between a
54 31 nursing facility's submittal of cost reports and
54 32 receipt of the reimbursement based upon these cost
54 33 reports.
54 34 b. The targeting of appropriations to provide
54 35 increases in direct care worker compensation.
54 36 c. Creation of a nursing facility provider tax.
54 37 8. Any option considered by the committee shall be
54 38 consistent with federal law and regulations.
54 39 9. Following its deliberations, the committee
54 40 shall submit a report of its findings and
54 41 recommendations regarding improvement in direct care
54 42 worker wages and other compensation in the nursing
54 43 facility setting to the governor and the general
54 44 assembly no later than December 12, 2008.
54 45 10. For the purposes of the initial review,
54 46 "direct care worker" means nonlicensed nursing
54 47 facility staff who provide hands-on care including but
54 48 not limited to certified nurse aides and medication
54 49 aides.
54 50 Sec. 71. DIRECT CARE WORKER IN NURSING FACILITIES
55 1 == TURNOVER REPORT. The department of human services
55 2 shall modify the nursing facility cost reports
55 3 utilized for the medical assistance program to capture
55 4 data by the distinct categories of nonlicensed direct
55 5 care workers and other employee categories for the
55 6 purposes of documenting the turnover rates of direct
55 7 care workers and other employees of nursing
55 8 facilities. The department shall submit a report on
55 9 an annual basis to the governor and the general
55 10 assembly which provides an analysis of direct care
55 11 worker and other nursing facility employee turnover by
55 12 individual nursing facility, a comparison of the
55 13 turnover rate in each individual nursing facility with
55 14 the state average, and an analysis of any improvement
55 15 or decline in meeting any accountability goals or
55 16 other measures related to turnover rates. The annual
55 17 reports shall also include any data available
55 18 regarding turnover rate trends, and other information
55 19 the department deems appropriate. The initial report
55 20 shall be submitted no later than December 1, 2008, and
55 21 subsequent reports shall be submitted no later than
55 22 December 1, annually, thereafter.
55 23 Sec. 72. EFFECTIVE DATE. This division of this
55 24 Act, being deemed of immediate importance, takes
55 25 effect upon enactment.>
55 26 #____. Title page, line 3, by striking the words
55 27 <end-of=life care decision making> and inserting the
55 28 following: <long-term living planning and patient
55 29 autonomy in health care>.
55 30 #____. Title page, by striking line 8 and inserting
55 31 the following: <transparency, health care consumer
55 32 information, health care access, the direct care
55 33 workforce, making appropriations, and including
55 34 effective date and applicability provisions.>>
55 35
55 36
55 37
55 38 HEDDENS of Story
55 39 HF 2539.309 82
55 40 pf:av/rj/11643